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IN THIS ISSUE

DYING GAUL. *In the Capitoline Museum, Rome. Copy of a bronze original belonging to the Dedication of Attalus I at Pergamon 241-225 B.C.*

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Suid-Afrikaanse Tydskrif vir Geneeskunde

Vol. 25, No. 2 Cape Town, 13 January 1951 Weekly 2s

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LOWER UMFOLOSI AND DISTRICT WAR MEMORIAL HOSPITAL

Applications are invited from suitably qualified medical practitioners for appointment to posts (2) of visiting medical officer to the Lower Umfolosi and District War Memorial Hospital.

These posts carry an honorarium at the rate of £60 per annum and will endure for not longer than 12 months.

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Natal Provincial Administration

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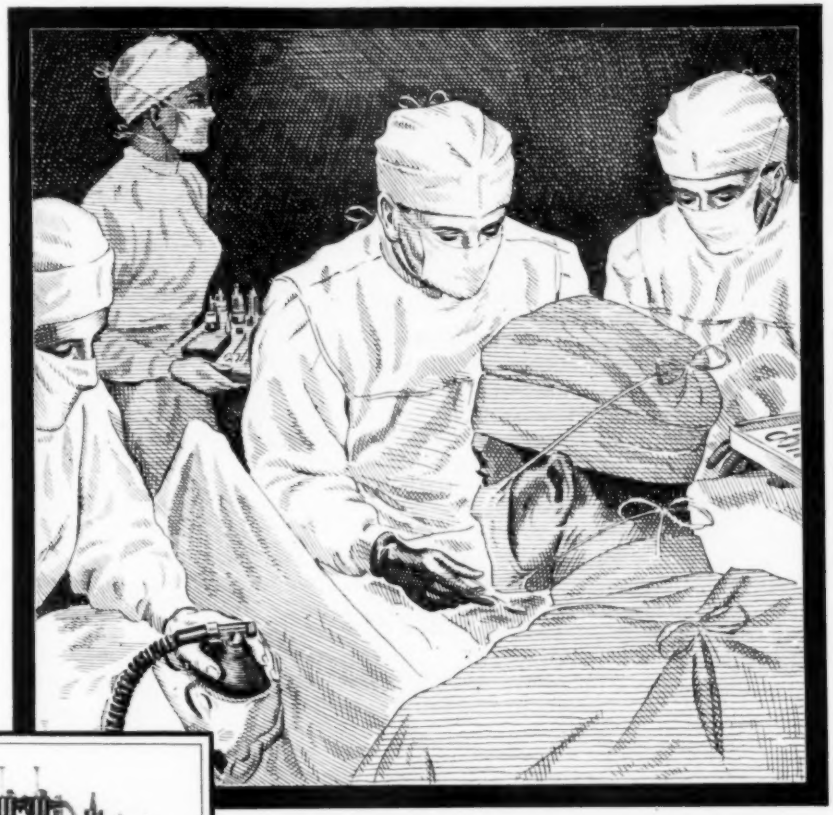

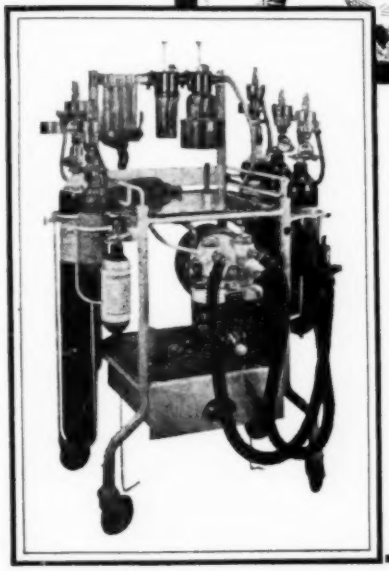

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THE EDENDALE JOINED TWINS

L. R. Tibbit, M.B., Ch.B.
Pietermaritzburg

As there appear to be few autopsies on joined twins described in the medical literature, it has been decided to publish a report of this case. There are numerous descriptions of the external appearance of joined twins; examples are the better-known Brighton twins, The Bohemian Blazek twins, and Chang and Eng Bunker, who all lived to adult life, mostly earning their living by circus employment.

The Birth of these female twins in August 1949 apparently presented no particular difficulty and they made excellent progress until half-way through their fifth month. Then a severe cough started in the left twin, followed by fever and gastro-enteritis in both. On the third day of illness the respiration of the left twin ceased. The right twin died 10 minutes after the left. During their life the twins were exhibited by their parents for gain.

POST-MORTEM EXAMINATION

Gross External Appearance (Fig. 1). The weight was 11 lb. 2 oz. The heads, necks, arms and chests were those of two separate babies showing signs of marked dehydration. Those parts were facing each other. The twins were joined from the costal margins downwards, and appeared to have one pelvic girdle between them, with two normal 'anterior' legs, except that the right showed a marked degree of talipes equino-varus. Attached to the posterior part of the pelvic girdle was a larger 'third' leg with a thicker calf and thigh. This third leg was a partially duplicated lower limb, presenting a double foot with a total of nine toes. The big toe had remained fused. There was a single umbilicus slightly to the right of the midline of the common abdominal wall.

External Genitalia and Anus. There were two sets of external genitalia in the perineum. For the sake of description the sets of genitalia are termed 'anterior' and 'posterior'. There was one anus only, between the anterior and posterior genitalia. The anterior genitalia consisted of two labia majora and minora with the urethra in the usual position in the vestibule. Lying posterior to that was a vagina traversed by a septum which divided it longitudinally into two equal halves. The posterior genitalia consisted of a vagina anteriorly, behind which there was a dimple only in place of the urethral opening, surrounded by labia minora only (Fig. 2).

Cranial Cavities and Spinal Cords. There appeared to be no abnormalities in the cranial cavities. Each twin had a separate central nervous system and a complete vertebral column, including a separate sacrum and coccyx.

Thoracic Cavities. Both pairs of lungs and both hearts appeared anatomically normal. The two hearts were

Fig. 1. The Anterior View of the Edendale Joined Twins.

equal in size. The left lung of the left twin showed an advanced broncho-pneumonia. The aorta of each twin was anatomically normal.

Fig. 2. A Diagram of the Disposition of the External Genitalia and the Anus in the Edendale Joined Twins.
(a) Labium majus.
(b) 'Anterior' urethra.
(c) Labium minus.
(d) Vagina with septum.
(e) Anus.
(f) 'Posterior' vagina.
(g) Urethral 'dimple'.
(h) Labium minus.

Diaphragm. This roofed in the single abdominal cavity completely, but was obviously double in structure. There were four crura, one pair for each vertebral column.

Abdominal Viscera. Situated under the double diaphragm there was one large liver, obviously also a double structure. There were two gall bladders, one on each side of the liver (Fig. 3). The obliterated umbilical vein ran to the right of the mid-line into a falciform ligament situated under the costal margin of the right twin. On penetrating the liver substance, the vein divided into two main branches. After some liver substance had been removed, the right-hand branch was seen to run to the inferior vena cava of the right twin, and the left-hand branch to the inferior vena cava of the left twin. There must therefore have been a ductus venosum for each twin during intra-uterine life.

The obliterated umbilical arteries were continuations of the 'anterior' umbilical arteries of each twin, and were in close contact with the 'anterior' bladder (Fig. 4). (The terms 'anterior' and 'posterior' are used for purposes of description as the twins were facing each other.)

Gastro-Intestinal Tract. The spleen, oesophagus, stomach, bile ducts, pancreas, duodenum and jejunum appeared all to be normal and separate in each twin (Fig. 5). However, approximately eight inches above the ileo-caecal junction, the ileum of each twin joined in a Y-shaped manner, and a common terminal ileum ran into a common caecum which presented a long vermiform appendix. The large bowel and anus was common to both twins, the caecum lying in the right iliac fossa of the right twin; and the rectum in the posterior part of the common pelvic cavity behind the 'anterior' set of internal urogenital organs.

Pelvis and Pelvic Cavity. Each twin had a set of two hip bones and a sacrum. The anterior part of the girdle consisted of normal-shaped pubic rami joined as usual at the pubic symphysis, except that one 'anterior' hip bone from each twin entered into the joint. The two 'posterior' hip bones, one from each twin, were normal in shape as far as the iliac crests, ilia, and sciatic notches were concerned; but instead of there being another pubic symphysis as anteriorly, the pubic rami and ischium of each side fused into a spindle-shaped mass of bone posteriorly. The acetabulum for the single hip joint of the third leg was seen on the outer aspect of this spindle of bone.

The contents of the common pelvic cavity from before backwards were an 'anterior' bladder, uterus and appendages, rectum and a 'posterior' bladder, uterus and appendages. Thus the uro-genital system had been duplicated while the hind gut had remained single.

Urinary Tracts. The two 'anterior' kidneys (one from each twin) were larger than one would have expected. The two corresponding ureters appeared normal and ran

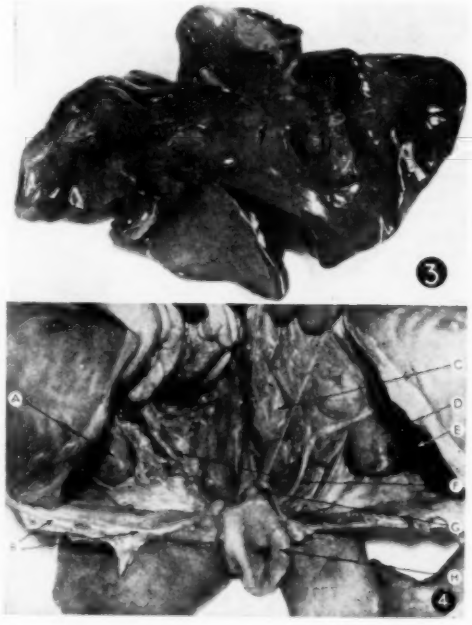

Fig. 3. The Inferior Surface of the Double Liver showing Two Gall Bladders.

Fig. 4. A Dissection to Show the 'Anterior' Set of Uro-genital Organs with the Small Intestines Retracted Posteriorly.
(a) Kidney.
(b) Obliterated umbilical vein and right umbilical artery.
(c) Rectum.
(d) Kidney.
(e) Spleen (L).
(f) Ureters.
(g) Uterus and appendages.
(h) Bladder.

into the 'anterior' bladder, the urethra of which has already been described (Fig. 5).

The two 'posterior' kidneys were very small with surprisingly large, dilated, convoluted ureters running into a large, flattened bladder situated retroperitoneally against the spindle of bone, which represented the duplicated ischium and pubis. The ureteric orifices of the bladder were of the large, almost 'golf-hole' variety. There was a dimple at the anterior angle of the trigone where the urethral orifice should have been. In the absence of a duplication of the hind gut, the 'posterior' urinary bladder and urethra could not develop normally. For this reason the 'posterior' kidneys were atrophied.

Fig. 5. A Dissection to Demonstrate the Y-Shaped Junction of One Ileum from Each Twin.

Uteri and Appendages. The 'anterior' uterus was anatomically normal with normal appendages and situated behind the 'anterior' bladder (Fig. 5).

The "posterior' uterus and appendages showed abnormalities in their formation. This abnormal uterus lay to the left of the 'posterior' bladder and was broad at its base for about one inch, but the fundus became a long, thin tube 1½ inches long, which ended by dividing into two Fallopian tubes, making a partially bicornuate uterus. The 'posterior' ovaries were smaller than the 'anterior' pair.

Aortae and Circulatory Anastomosis. Each twin had an independent abdominal aorta running along its vertebral column. In the lower lumbar region each aorta divided into two common iliac arteries—one pair directed forwards, and the other backwards. The distribution of the 'anterior' common iliac arteries was normal with the external iliac continuing into a femoral artery for each normal limb, and an internal iliac artery continuing into an obliterated umbilical artery on each side of the 'anterior' urinary bladder (as previously described) after giving off the other normal branches.

There was no counterpart to these arteries posteriorly, but a very marked and interesting circulatory anastomosis between the twins had occurred. The two 'posterior' common iliac arteries (one from each twin) did not branch in a normal manner, but formed an anastomotic arch in the posterior part of the pelvis. From this arch arose branches on the concave side for the pelvic viscera. The two largest branches arose from the convex side, and left the pelvic cavity in the same way as do the gluteal arteries normally. Each of these two arteries accompanied a sciatic nerve (one from each twin) through the 'posterior' sciatic foramina into the thigh of the duplicated third lower limb on the posterior aspect of the joined twin.

The Third Leg. There was a single, large femur with a very short neck. The tibia appeared single, but the fibula was almost as thick as the tibia and appeared to be formed by the fusion of two bones.

The hip joint showed no marked deviation from the normal. The knee joint was normal except that there were two sesamoid bones, presumably patellae, one on each side of the joint. Each patella had a set of quadriceps muscles and there were two tibial tuberosities for the insertion of the latter.

The ankle joint appeared to have a third malleolus posteriorly, emanating from the base of the double fibula. There appeared to be a single calcaneum, a double fused talus, and the remainder of the skeleton of the foot was made up of two sets of tarsals, metatarsals and phalanges arranged around a double fused first metatarsal and the phalanges which formed the fused big toe.

Two femoral arteries and femoral nerves were present in the third leg, the former derived from the 'posterior' common iliac arteries, and the latter from the lumbar nerves arising on the adjoining sides of the vertebral columns. The femoral arteries were very small, most of the blood supply of the third leg being derived from the branches of the anastomotic arch which passed through the sciatic foramina, as already described. The sciatic nerves, one from each twin, traverse the two sciatic foramina, and passed side by side down the middle of the back of the thigh.

DISCUSSION

Theories of Modes of Twinning. There are two main theories to explain the formation of double monsters; on the one hand the 'fission' theory, and on the other hand the 'fusion' theory.[1]

The former theory has received the most support on the grounds that, in all the cases dissected, a definite pattern of degrees of fission has existed, correlating the external appearance with the manner in which internal organs remain common to both twins. In fact, the expert

embryologist can foretell with a fair amount of accuracy whether it is possible to separate a pair of joined twins surgically or not, judging from the external appearance. Where the fission is complete, of course, the result is a pair of uniovular, identical twins. A further point against the 'fusion' theory is that these double-headed monsters are always joined at identical points. Thus they cannot be due to the junction of the two previously separated embryos, because in that case one would expect them to be joined irregularly sometimes.

The splitting is thought to occur at the embryonic plate stage, and to occur longitudinally, thus forming two embryonic areas lying side by side in their long axes.

In some cases, the splitting occurs at the cephalic end only, giving rise to double-headed monsters, and in other cases at the caudal end, giving rise to monsters with four legs and perhaps also double genitalia, depending on the extent of fission. In yet other cases the split appears to arise simultaneously at the cephalic and caudal ends.

The double-headed monsters so far dissected have all had completely separate neural tubes and vertebral columns, as well as separate hearts, which gives reason for the theory that the split of the embryonic plate also occurs dorso-ventrally.[1]

If the various kinds of double formations arise through partial fission of the embryonic plate, the processes of splitting revealed by the anatomical study of such monsters are directly applicable to the process of splitting of normal, identical twins. Definite rules of the sequence of the fission have thus been formulated by the dissection of such double monsters, *viz.*:—

A dorso-ventral splitting of the cardiac and neural groove areas followed or accompanied by a splitting in the primitive streak area from which are derived the genital organs and the lower limbs.

Next in sequence would be a fission of the entoderm layer, beginning simultaneously at the cephalic and caudal ends, and separating last of all in the midgut region.

Finally, the double embryonic plates would come apart sufficiently in a lateral direction to allow two normal uniovular twins to develop side by side within the single amniotic cavity.

Applying this theory to the monster described, the fission must for some reason have been arrested at the stage where the primitive streak area, and also the entoderm layer were only partially split, while the splitting of the cardiac and neural groove areas was complete.

Theories of Reasons for Twinning. Various experiments have been carried out on lower animals whereby monsters were produced by changes of environment.[2] Stockard (1921) suggested that a change in the supply of oxygen was the most likely factor. This, occurring at a crucial period in the development of the embryo, might arrest the normal pattern. He also was able to produce double monsters in fish by lowering the temperature at a critical period. As far back as 1893, Wilson and Loeb experimentally separated two primary blastomeres to form twins.

Spemann in 1901 was able to produce double monsters by partial constriction of the egg during later stages of blastula or gastrula.

Withei (1934) recognized over-ripeness of eggs of the frog as a causative factor in the production of identical and joined twins, the eggs being no longer capable of normal, axiate division. Applied to placentate animals the tendency to retain the ovum within the follicle until it is over-ripe, is probably based on endocrine factors, and these may be of a hereditary type. If such is the case, the longer the ovum is retained, the less will be its power to divide normally into uni-ovular twins and the greater the likelihood of a double monster resulting. This latter theory is the most acceptable, as environmental factors are unlikely to affect the zygote in the interior of the uterine cavity.

SUMMARY

The anatomical features of a pair of joined twins which lived to the age of five months, are described.

The theories and mechanism of partial twinning are discussed.

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Unusually small amounts are required for thorough cleansing and disinfection. pHisoderm with hexachlorophene 3% has definite bacteriostatic and bactericidal properties. In addition to its immediate effect it has a cumulative antibacterial action. If pHisoderm with hexachlorophene 3% is used routinely and exclusively, the pre-operative scrubbing time can be reduced considerably, compared to former techniques, without any reduction in antiseptic activity, and the skin usually will remain in a state approximating sterility for hours after the last use.

Indications: For surgical preparation of operating team and for patient preparation, including cleansing of open wounds. Particularly suitable for cases in which the use of soap is contra-indicated. Useful adjunct in eczema, seborrhoea, acne and certain skin and scalp infections. Recommended for washing, swabbing or irrigating genital mucous membranes.

How Supplied: Bottles of 16 fl. oz. and 1 gallon, and 3 fl. oz. re-fillable hand dispensers for wash room or emergency bag.

Ordinary soap dispensers should not be used. Special re-fillable dispensers made with metals and plastics compatible with pHisoderm with hexachlorophene 3% can also be supplied; 30-oz. pedal type for attachment to wall or portable stand.

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VAN DIE REDAKSIE

REGISTRASIE VAN OPTOMETRISTE

Met die ontwikkeling en uitbreiding van mediese dienste het sekere tegniese werkwyses wat 'n inherente deel van die gebied van mediese praktyk uitgemaak het, genoegsame status bereik om hulle afskeiding van die funksie en pligte van mediese praktisyns en hulle toewysing aan persone wat in toereikende mate opgelei is in die geskikte tegnieke, te regverdig. Masseurs, voetkundiges, radiograwe, ens., is goeie voorbeelde van hierdie ontwikkelingspatroon in mediese praktyk.

'n Soortgelyke situasie is met verloop van tyd geskep ten opsigte van die voorskryf en verskaffing van lense vir refraksiefoute; maar hier was die ernstige gevolg 'n menigte behoorlik en onbehoorlik gekwalifiseerde persone wat hulle bestaan uit hierdie werk maak. Die beskerming van die gesigsvermoë is 'n uiters belangrike diens en dit is klaarblyklik in die openbare belang dat daar aangedring word op standaarde van bekwaamheid om te verseker dat daar behoorlike vaardigheid en sorg uitgeoefen word. Vir optometriste is opleidingstandaarde daargestel wat die Geneeskundige Raad sonder enige aarseling kan erken as toereikend vir die beperkte tegniese doel voor oë. Weens die afwesigheid van geskikte wetgewing is die gebied egter oop vir enige kwaksalwer om op ongelyke voet mee te ding met fatsoenlike optometriste wat 'n besliste etiese standaard van praktyk nakom en dus 'n aansienlike agterstand het om in te haal; want 'n heeltemal ongekwalifiseerde kwaksalwer kan vandag die liggelowigheid van 'n publiek uitbuit wat hom maklik 'n rad voor die oë laat draai. Dit is dus redelik om aan te dring dat uitvoering gegee word aan 'n beleid wat die ware opometris sowel as die publiek sal beskerm.

In sommige kringe het ongegronde vrees ontstaan dat sulke wetgewing sal vereis dat die pasiënt slegs deur bemiddeling van 'n geregistreerde geneesheer na die optometris verwys word.[1] Hierdie vrees is geheelenal ongegrond en strydig met die algemeen erkende praktyk van die mediese beroep asook strydig met die beleid van die S.A. Geneeskundige en Tandheelkundige Raad. Die mediese beroep erken reeds vir geruime tyd die toereikende en nuttige plek wat behoorlik opgeleide optometriese tegnici in hierdie belangrike diens kan vul en sal sonder om te aarsel sterk steun verleen aan behoorlik gekwalifiseerde opmetriste by die beskerming van hulle beroep.

Dit is waar dat in baie gevalle die verbetering van 'n refraksiefout iets betreklik makliks is. Dit is egter nie

1. Die *Cape Times*, 1 Desember 1950.

EDITORIAL

REGISTRATION OF OPTOMETRISTS

With the development and expansion of medical services, certain technical procedures, inherently within the field of medical practice, have assumed a sufficient status to justify their separation from the function and duties of medical practitioners and their delegation to persons adequately trained in the appropriate techniques. Masseurs, chiropodists, radiographers, etc., are good examples of this evolving pattern in medical practice.

A similar situation has, in the course of time, been created in respect of the prescription and the dispensing of lenses for errors of refraction; but here the serious result has been a multiplicity of suitably and unsuitably qualified persons who engage in this work for their livelihood. The protection of eyesight is a most important service and it is obvious that standards of competence to ensure that proper skill and care are employed must be insisted upon in the public interest. Standards of training have been developed for optometrists which the Medical Council would have no difficulty in recognizing as adequate for the limited technical objective in view. However, owing to the absence of any suitable legislation, the field is open to any quack or charlatan to compete on unequal and unfair terms with reputable optometrists who observe a definite ethical standard of practice and are thereby placed at considerable disadvantage; for a totally unqualified quack can to-day exploit the credulity of a gullible public. It is therefore reasonable to urge the implementation of a policy which will protect the genuine optometrists as well as the public.

In some quarters unfounded fears have arisen that such legislation would require the patient to be referred to the optometrist only through a registered medical practitioner.[1] These fears are entirely without substance and contrary to the generally accepted practice of the medical profession as well as contrary to the policy of the S.A. Medical and Dental Council. The medical profession has long recognized the adequate and useful place which suitably trained technicians in optometry can fulfil in this important service and would have no hesitation in strongly supporting properly qualified optometrists in the protection of their calling.

It is true that in many cases the correction of an error of refraction is a relatively easy procedure. It is not,

1. The *Cape Times*, 1 December 1950.

so eenvoudig soos dit lyk nie omdat die simptome waartoe refraksiefoute aanleiding gee, maklik die simptome van 'n ernstige onderliggende gestelsiekte kan wees waarvan die uitkenning 'n te groot verantwoordelikheid is om op die skouers van 'n opgeleide tegnikus te lê wat slegs op 'n klein en beperkte gebied bedrewe is. Die probleem wat dus ontstaan, is om 'n oplossing te vind vir die moontlike stryd wat kan ontwikkel tussen die wettige praktyk van die optometris en die onwettige pleging deur hom van dade wat spesiaal onder die beroep van die geneesheer ressorteer.

In verband hiermee behoort daar hoegenaamd geen moeilikheid te wees nie. Dit is welbekend dat die aanbring van pupilverwyders in die oog 'n prosedure is wat met die grootste gevaar vir die pasiënt gepaard kan gaan. Die gebruik van die oogspieël deur 'n tegnikus kan in sekere omstandighede ook onwenslik wees. Met die oog op die spesiale sielkundige en geneeskundige gevare waaraan jong kinders blootgestel kan word wanneer hulle verkeerde behandeling in verband met skynbare refraksiefoute ontvang, mag jong kinders daarbenewens ook 'n klas uitmaak wat uit die praktykgebeid van die optometris verwyder moet word.

Dit is kwessies van beginsel sowel as besonderheid maar hulle behoort geen onoorkomelike hindernis te bied nie vir die omskrywing van presies watter funksies die behoorlik opgeleide optometriste kan uitoefen by die verskaffing van lense vir volwassenes wat die verbetering van refraksiefoute nodig het.

Aangesien behoorlik opgeleide optometriste self die slagoffers van ongeskoolde en onopgeleide kwaksalwers is, is die doeltreffendste manier om hulle sowel as die publiek te beskerm, om voorsiening te maak vir hulle verpligte registrasie. Dit sal voorsiening maak vir die waarborg dat toereikende standaarde van bedrewenheid vereis word van diegene wat die beroep wil beoefen sowel as vir die uitskakeling van die kwaksalwer. Sodanige registrasie, alhoewel dit verpligtend sal moet wees, sal noodsaaklikerwys onder die bestuur en beheer van 'n liggaam soos die Suid-Afrikaanse Mediese en Tandheelkundige Raad val. Optometriste sou hulle aan geen groter verlies van hulle onafhanklikheid en vryheid onderwerp nie as wat aptekers, tandartse en geneeshere bereid was om in die openbare belang te doen. (Die lidmaatskap van die statutêre liggaam wat beheer oor geneeshere uitoefen, sluit leke, verpleegsters sowel as tandartse in.) Weens die klaarblyklike en noue verband wat met die praktyk van geneeskunde bestaan, sou dit heeltemal onredelik wees en sekerlik nie in die openbare belang nie om die register van optometriste van die beheer van 'n statutêre liggaam soos die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad weg te neem.

Alhoewel die verbetering van 'n refraksiefout *per se* 'n probleem van die fisika van lense is, is die oog 'n maklik bereikbare deel van die senuweestelsel en kan 'n aanduiding van ernstige gestelsversteurings en siekte gee. 'n Pasiënt wat 'n optometris besoek, moet in dié mate beskerm word dat hy nie die slagoffer van onbekookte en ontoereikende kliniese gissing word nie. Alhoewel dit dus heeltemal wenslik is dat die optometriste binne die raamwerk van die Geneeskundige Raad optree, is ons seker dat die mediese beroep asook die Geneeskundige Raad so 'n

however, as simple as it seems because the symptoms which errors of refraction give rise to may well be the symptoms of grave underlying systemic disease, the recognition of which is too great a responsibility to place upon a trained technician skilled only in a small and limited field. The problem, therefore, that arises is to resolve the possible conflict which might develop between the legitimate practice of the optometrists and his illegal performance of acts specially pertaining to the calling of the medical practitioner.

About this there should be no difficulty at all. It is well known that the instillation of mydriatics into the eye is a procedure which can be fraught with the gravest danger and peril to the patient. The use of the ophthalmoscope may also, in certain circumstances, be undesirable in the hands of a technician. In addition, in view of the special psychological and medical risks which young children may be subjected to if handled improperly in connexion with apparent errors of refraction, they may comprise a category of persons who should be removed from the scope of the optometrist's practice.

These are matters of principle as well as of detail, but they should offer no insuperable obstacle to the definition of the precise function which properly trained optometrists can assume in providing lenses for adults who require correction of errors of refraction.

Because properly trained optometrists are themselves the victims of unskilled and untrained quacks, the most effective way to protect them, as well as the public, is to provide for their compulsory registration. This will allow the safeguard of adequate standards of proficiency to be required of those who wish to practise this calling, as well as the elimination of the quack and the charlatan. Such registration, however, although it would have to be compulsory, must quite necessarily come under the guidance and control of a body such as the South African Medical and Dental Council. Optometrists would be submitting to no greater loss of their independence and freedom than pharmacists, dentists and doctors have been prepared to submit to in the public interest. (The membership of the statutory body which controls doctors includes laymen, nurses as well as dentists). It would be quite unreasonable, and certainly not in the public interest, to remove the register of optometrists from the control of a statutory body such as the South African Medical and Dental Council, because of the obvious and intimate connexion that exists with the practice of medicine.

Although the correction of an error of refraction *per se* is a problem in the physics of lenses the eye happens to be an easily accessible part of the nervous system and may give a clue to serious systemic disorder and disease. A patient visiting an optometrist should be protected to the extent that he does not become the victim of half-baked and inadequate clinical surmise. Although it is, therefore, completely desirable that the optometrists should function within the framework of the Medical Council, we feel sure that the medical profession as well as the Medical Council

mate van selfstandigheid vir optometriste sal verkry as wat met die openbare belang strook. Die besonderhede waarvolgens 'n Advieskomitee met toereikende verteenwoordiging van die optometriste vir die Geneeskundige Raad gevorm kan word, sal geen moeilikheid bied nie.

Die omstandighede van die optometriste verskil nie wesenlik van die ander mediese hulpdienste nie en hulle funksies kan toereikend gedek word in die bestek van 'n Wetsontwerp soos die Wetsontwerp op Mediese Hulpdienste wat reeds baie jare oorweeg word. So 'n Wetsontwerp sal 'n verpligte register daarstel vir die verskillende mediese hulpdienste wat in geskikte bylaes omskryf sal word en waaronder optometriste hulle regmatige plek sal inneem. Hulle sal die voorregte wat met 'n statutêre erkenning gepaard gaan met ander hulpdienste deel en hulle sal een van die toenemende aantal beperkte tegniese spesialiteitsgebiede uitmaak waarvan die mediese beroep in toenemende mate gebruik maak mits hierdie gebiede op 'n wetenskaplike wyse aangewend kan word.

Dit is waarskynlik dat die aanstaande wetgewende sessie uiters druk sal wees, maar daar word gehoop dat die Regering 'n geleentheid sal vind om hierdie uiters nodige wetgewing in te dien wat reeds lank agterstallig is.

would contrive for optometrists as great a measure of autonomy as is consistent with the public welfare. The details whereby an Advisory Committee to the Medical Council could be set up, with adequate representation for optometrists, would offer no difficulty.

The position of the optometrists is not inherently different from that of other medical auxiliaries, and their functions could adequately be covered in the scope of a Bill such as the Auxiliaries Bill which has been under consideration for many years. Such a Bill would create a compulsory register for the various medical auxiliaries which would be specified in appropriate schedules and amongst which optometrists would take their rightful statutory place. They would share with other auxiliaries the privileges which come with such statutory recognition and they would be one of the growing number of restricted technical specialties of which the medical profession makes use increasingly, provided these categories can be employed in a scientific manner.

It is likely that the coming legislative session will be an extremely heavy one but it is to be hoped that the Government will find an opportunity to introduce this very necessary and overdue legislation.

THE SURGERY OF PEPTIC ULCER

WM. G. SCHULZE, CH.M., F.R.C.S. (ENG.)
Cape Town

(*Concluded from p. 4*)

SURGICAL TREATMENT

THE INVESTIGATION OF CASES

Barium Meal. This will confirm the diagnosis in almost every case and is an essential forerunner to any kind of treatment. A negative X-ray does not exclude an ulcer.

Gastroscopy. This is an exceedingly valuable procedure, simple to perform and well tolerated by the average patient. It is especially useful for the case with a doubtful radiological report, and for the follow-up of patients receiving medical treatment.

Fractional Test Meal. This is of little value to the surgeon, except possibly to warn him that stomal ulceration may occur if the resection is inadequate. The fractional test meal determines only the degree of acidity of the gastric sump, without making provision for buffering. The estimation of the pH value of the gastric contents is of greater importance, but as yet this is not a practicable procedure. The test meal shows only the hormonal response to a meal, and this need not be abnormal in the ulcer patient.

The night secretion of gastric juices is probably a result of neurogenic hypersecretion and the estimation of this secretion would be of far greater assistance to the surgeon. In the normal subject, 400 to 500 ml. or less are secreted in 12 hours, with a free acid level of 0 to 60 units. In the duodenal ulcer patient, the night secretion may be 800 ml. and more, with a corresponding increase in acid value.

Blood. It is essential to have a haemoglobin estimation done on all patients before operation, and no major surgery should be contemplated in the presence of a Hb value of less than 75% (11.1 gm.). In this respect it is important to bear in mind that blood given before the operation is of far greater value than when given post-operatively.

INDICATIONS FOR SURGICAL TREATMENT

The practitioner who advises an elderly patient suffering from gastric or duodenal ulcer against operation takes upon himself a greater responsibility than he would in recommending surgical intervention. The morbidity and mortality following medical treatment are very much higher than when surgery is employed, and the results of surgery in the elderly patient are exceedingly good provided the physician refers his case in good time.

Duodenal Ulcer should be treated medically in the following circumstances:

(a) In the uncomplicated case where the symptoms have been present only a short while.

(b) In patients under 30 years of age where there are no complications.
(c) In the elderly patient with mild symptoms and no complications.
(d) In the psychoneurotic patient with no complications.
(e) In the patient who is suffering in addition from some medical complaint which would make operation hazardous.

Surgery is indicated in the following type of case:—

(a) Where any of the following complications are present:
i. Perforation.
ii. Pyloric stenosis.
iii. Haemorrhage.
(b) In the presence of dual or multiple ulcers.
(c) Where pain continues in spite of adequate medical treatment.
(d) Where there is recurrence of symptoms within three months of medical treatment, especially in a robust working man.
(e) Where ulceration has recurred following operations such as:
i. Simple closure of acute perforation.
ii. Inadequate operation such as gastro-enterostomy.

Gastric Ulcer is treated medically:

(a) Where the patient is young.
(b) Where there is only a short history of indigestion.
(c) Where the ulcer is small and is situated in the vertical part of the lesser curvature.

This type of case may continue with medical treatment provided the ulcer has healed within a month as confirmed by radiological or preferably by gastroscopic examination. In addition it is essential for this patient to be re-examined by these means at regular intervals afterwards. The great majority of gastric ulcers should be looked upon as surgical from the commencement and especially when the following conditions apply:

(a) In the presence of complications:—
i. Perforation.
ii. Hour-glass contraction.
iii. Haemorrhage.
iv. Malignant change.
(b) Where the patient is 50 years of age or more, has an ulcerating lesion, but has complained of dyspepsia for only a short time.
(c) Where the ulcer is situated on the greater curve or in the pre-pyloric area.
(d) Where the ulcer is associated with achlorhydria.
(e) Where the ulcer has not healed after one month of rigid medical treatment, in hospital.

PERFORATION

There was a short period within recent times when a case was made for the treatment of acute perforation on conservative lines by means of continuous gastric suction and large doses of antibiotics. It is generally agreed, however, that it is safer and wiser surgery to operate on these cases as soon as the diagnosis is established.

Gastric suction by means of a Ryle's tube is instituted as soon as the patient is admitted to hospital, and operation is performed as soon as possible, the procedure consisting of simple closure of the perforation, as described by Roscoe Graham. The extravasated gastric contents are aspirated from the peritoneal cavity. The abdomen is closed without drainage, and gastric suction is continued for two to three days after operation. Because of the oedematous nature of the tissue to be sutured, one cannot be absolutely certain that closure will be adequate, and in most cases the sealing-off process must be attributed to nature. The main purpose of the operation is to remove as much as possible of the acid juices in the peritoneal cavity, while continued suction after operation serves to relieve tension within the stomach while Nature attends to the perforated area.

There are very few indications indeed for doing any more at the operation than what has been described. It must be borne in mind that the patient has an acute abdomen and no matter how recent his perforation, he is not an ideal subject for a partial gastrectomy. Moynihan taught that it was a good rule to make the patient safe for surgery whenever this was possible and this rule applies to-day as much as it did then.

It must also be borne in mind that at least 30% of perforations remain symptom and ulcer free after this simple operation; 70% of patients will return sooner or later with a recurrence of ulceration, and it is essential, therefore, to institute a follow-up on all cases after discharge from hospital. An X-ray should be carried out in three months and repeated at regular intervals afterwards. Recurrence of ulceration, even in a young patient, is a clear indication for partial gastrectomy.

PYLORIC STENOSIS

A number of different pathological entities may give rise to obstruction at the pylorus, but far and away the commonest cause for this is scarring of the proximal part of the duodenum due to long-standing duodenal ulceration. By the time signs of obstruction manifest themselves, active ulceration has ceased, and it is rare at operation to find an active ulcer. At the same time, the symptomatology changes, the previous 'hunger pain' being replaced by a feeling of fullness; whereas formerly the patient's symptoms were relieved by eating, they are now accentuated. Vomiting gradually becomes a more frequent occurrence, until finally it becomes copious, and the vomitus contains food taken a long time before. At this stage the patient is undernourished, dehydrated, alkalaemic and hypochloraemic. The blood N.P.N. is elevated, but it is uncommon for these patients to present with tetany unless they have had large doses of alkali.

The patient requires operation urgently, for it is a life-saving measure; but he is in no condition for operation, and it requires usually several days of carefully planned pre-operative management to prepare him for it. Most important of all, he requires water, salt and vitamin C, and in all probability his blood proteins are depressed so that he will need plasma, and possibly blood as well.

In the severely dehydrated patient, there is usually a considerable amount of renal damage, so that it is very important to exercise particular care about the amount of saline administered intravenously. The damaged kidney may find difficulty in excreting excess salt, and it is important to bear in mind that determination of plasma chlorides is of little value and may in fact be misleading. The simple Fantus test for urinary chlorides will give much more useful information, and it is a safe rule in these cases to maintain the urinary chlorides in the neighbourhood of 1.5%.

The operation of choice in these cases depends to some extent on the age of the patient. In a patient under 40 years of age it would be unwise to perform a gastro-enterostomy even if (and this is usually the case) the gastric acidity before operation is low. After gastro-enterostomy in the young patient, it is usual for the gastric acidity

to return within about a month, and the patient then runs the risk of stomal ulceration at a later date. In the older patient, where the possibility of recurrent ulceration is unlikely, and where the patient's general condition is poor, gastro-enterostomy is a life-saving operation, and the results are excellent.

HAEMORRHAGE

The subject of gastro-duodenal bleeding is a very large one and it is possible here merely to touch on the more important points. Generally speaking, there is to-day still considerable diversity of opinion, not so much on what type of operation to be employed, but whether medical or surgical treatment should have preference. It is certainly not always easy to decide whether a particular patient should continue with medical treatment and allow nature to seal up his bleeding vessel, or whether this should be done surgically; and it is not possible to lay down very hard and fast rules regarding the indications for surgery. The assessment of these cases will be influenced to a large extent not so much by his general appearance when seen and not so much by his immediate response to medical treatment; but far more by a thorough knowledge of the pathology of the lesion and the prognosis of gastro-duodenal haemorrhage in general. The decision whether to operate must of course also depend on the facilities available, and the experience of the surgeon.

About 20% of peptic ulcer patients develop bleeding at some time or other during the course of their illness; 70% of haemorrhages, and more than 90% of the deaths from haemorrhage, occur in patients over 40 years of age.[10, 11] The young patient, of under 40 years of age, is not in great danger of losing his life, even with a massive haemorrhage. It has been shown that in this age group the mortality from haemorrhage is a fraction of 1%, and that even in cases of massive haemorrhage, the death rate is less than 1%.[12] Over the age of 45, the danger from haemorrhage increases profoundly, and all authorities on the subject are agreed on this point.[13-17] At this time of life, the ulcer usually has a considerable amount of scar tissue in its base which has the effect of holding open the bleeding vessel. The vessels, too, show a variable amount of arteriosclerotic change, which has a similar effect on the open end.

In addition to these facts (and this is a point of considerable importance) old people tolerate severe bleeding very badly. The period of hypotension occasioned by the haemorrhage, even if adjusted later by ample blood transfusion, is exceedingly dangerous. Certain irreversible changes occur at this time, probably in the liver, which seal the doom of the patient, so that no matter what form of treatment is adopted subsequently, the patient inevitably dies. He dies usually on the fifth to the eighth day in a state of uraemia. The only thing that can possibly save this type of patient is early operation, at the commencement of his bleeding. Bleeding in an old patient is a surgical emergency.

Continuation or recurrence of bleeding, while the patient is in hospital undergoing treatment, is a grave sign. It has been shown that of patients who continue to bleed on the second or third day after the beginning of the bleeding, no less than 80% die 48 hours later.[18] Haematocrit and haemoglobin estimations in these cases, to assess whether bleeding is continuing, are fallacious and often give rise to a false sense of security. The best rough practical guide is the systolic blood pressure and the pulse rate.

Of patients who die as a result of bleeding peptic ulcer, 4% do so of their first haemorrhage, 40% of their second, and 56% of their third or later haemorrhage.[19]

Pain preceding haemorrhage or persisting in spite of treatment is an ominous sign. It means that the ulcer is a very acute one, and only urgent surgery will save this patient.

Perforation occurring concurrently with bleeding carries with it a very high mortality rate. This is one of the few indications for partial gastrectomy in the presence of perforation.

Indications for Operation. In the first place, it must be established with reasonable certainty that the patient has a peptic ulcer.

A patient who gives a short history of dyspepsia, or no previous history of dyspepsia, is unlikely to die from a bleeding peptic ulcer, even if his haemorrhage is considered to be severe. If the patient is young, he should be treated conservatively.

Operation should be advised and carried out as soon as possible in the following types of case:—

(a) Where bleeding continues for more than 36 to 48 hours in a middle-aged patient.
(b) Where bleeding has recurred even once in a middle-aged patient.
(c) Where bleeding begins or recurs while the patient is undergoing medical treatment for peptic ulcer, no matter what his age.
(d) Where bleeding is accompanied by pain.
(e) Where bleeding is accompanied by perforation.

It is now generally accepted by physicians that the mortality in the above types of case, when treated conservatively, is very high indeed. Avery Jones and others estimate it to be more than 50%, while early surgery in good hands will reduce this to about 5%.[20, 21] Norman Tanner[22] was able to show recently that his overall mortality when treating bleeding ulcer by urgent surgery (and this included a high percentage of very old people) had been reduced to 7%.

The Operation. This will depend to some extent on the experience of the surgeon, but it is now generally accepted that the ideal procedure is a partial gastrectomy. Lewis[23] points out that there are two provisos regarding the surgeon who undertakes these cases:

(a) He must be able to do an ordinary gastrectomy soundly and well in a little over the hour;
(b) He must be prepared to deal with these cases at any time of the day or night.

HOURGLASS STOMACH

Several conditions may give rise to this deformity, but at least 90% are due to gastric ulceration, which is usually of very long standing. It occurs almost exclusively in women. When seen for this condition, they are usually elderly and feeble. In 30% of cases there is an associated pyloric stenosis, while the causative ulcer may be active or healed.

Treatment in these cases depends on various factors. If the ulcer is still active, and especially if pyloric stenosis is present, partial gastrectomy is the only operation worthy

of consideration. However, many of the patients are not fit subjects for this radical procedure, and should there be no obvious sign of pyloric obstruction, and should the ulcer be considered inactive, a gastro-gastrostomy is a very simple and satisfactory procedure. This operation consists of a simple anastomosis of the two stomach pouches to each other. Posterior anastomosis of the proximal pouch with the jejunum is also a useful procedure, but applicable only in those cases where the ulcer has healed and in the absence of pyloric stenosis.

OPERATIONS FOR DUODENAL ULCER

Many varieties of operation have been employed from time to time for the cure of duodenal ulcer, including amongst others: excision of the ulcer with pyloroplasty of one kind and another, gastro-enterostomy, partial gastrectomy, more recently, vagotomy; and vaso-ligation.

Gastro-enterostomy, pyloroplasty and other forms of gastro-duodenostomy are no longer done for active duodenal ulceration—at least not by themselves. They are used to-day only in conjunction with vagotomy, but as a definitive procedure for duodenal ulceration they have no place in modern surgery.

These operations carry with them a grave risk of future stomal ulceration and gastro-jejuno-colic fistula. Most authorities on the subject state that the incidence of stomal ulceration is as high as 30% following gastro-enterostomy.[32] This operation was popular from 1900 to 1925 and since then it has been replaced almost completely by gastrectomy.

This operation has given better results than any other which has been used in the past or which has been substituted for it since. The operative mortality is to-day less than 2%, while in expert hands it is a fraction of 1%. More than 90% of patients are restored to normal health, completely symptomless, able to return to full working capacity, requiring no alkaline powders or dietary restrictions, and the incidence of stomal ulceration is less than 1%.

These figures naturally apply to those cases which have had an adequate resection, and they are the figures of experts. Partial gastrectomy is usually not a difficult operation in experienced hands, but unfortunately the occasional surgeon or the dilettante too frequently reduces the operation to what is little more than a pyloric circumcision.

The important points in planning the operation are as follows:

The resection must be adequate and should include almost the whole of the lesser curve, while on the greater curve the section should be at the level of the second vas brevis. Allen has shown that where the lesser curve measurement in the resected specimen is over 11 cm., the incidence of anastomotic ulcer is rare, whereas this becomes a fairly common complication when the lesser curve measures less than 10 cm.[24]

The pyloric antrum must be removed completely, and if this is found to be impossible, the whole of the antral mucosa must be removed by the Bancroft procedure.[25] The worst results of gastrectomy occur in those cases where the surgeon has failed to remove the whole of the pyloric antrum.[26]

The proximal loop of jejunum should be as short as possible without causing kinking of the bowel. The nearer the stoma is to the duodeno-jejunal flexure, the less the likelihood of stomal ulceration, and the less the incidence of post-gastrectomy syndromes.[27]

A valve (Lake-Hoffmeister) should always be fashioned at the anastomosis, leaving a stoma no larger than the diameter of the jejunum. All modern surgeons are agreed on the wisdom of making a valve at the anastomosis.

When possible, a retro-colic anastomosis should be made as this is more physiological, but in cases of high gastric acidity where a high gastrectomy is planned, the ante-colic anastomosis will have to be done. In general, the results appear to be about equal whether the anastomosis be anterior or posterior, and the choice will depend largely on the surgeon's preference.

VAGOTOMY

Great enthusiasm swept the modern world when this operation was introduced for the treatment of duodenal ulcer, but this has now dwindled very considerably, so that there are to-day very few surgeons in the larger hospitals and clinics overseas who use the operation for this purpose.[28, 29]

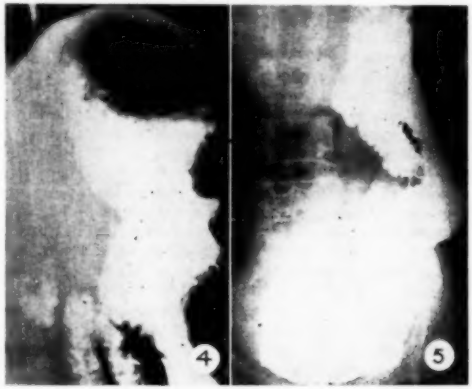

Fig. 4. Large jejunal ulcer immediately beyond stoma.
Fig. 5. Three months after vagotomy. No evidence of ulcer.

It is generally agreed that the only real indication for this operation is in the treatment of stomal ulcer following partial or sub-total gastrectomy. In these cases, the results are indeed dramatic. Figs. 4 and 5 are barium meal X-rays of a patient aged 33 years who had had duodenal ulceration for eight years. Five years before, a gastro-enterostomy was done which was followed by stomal ulceration, and then a partial gastrectomy was done two years later. Another stomal ulcer developed and a more radical gastrectomy was performed a year later. Fig. 4 shows a large jejunal ulcer, and the patient stated that he had never been free from pain for longer than one month following his first operation. Vagotomy was performed and the second X-ray shows the appearance after three months. When last seen some six months after the vagotomy, the patient was still completely symptom free, and there was no sign of ulcer.

VASOLIGATION

Wilson Hey[30] and Somervell[31] have recommended ligation of the majority of the vessels supplying the stomach in an attempt to reduce the gastric secretions. The operation has not found favour.

OPERATIONS FOR GASTRIC ULCER

Partial gastrectomy is the operation of choice for gastric ulcer, and there is a growing tendency overseas to use the Billroth I operation whenever possible not only for gastric ulcer but also for certain cases of duodenal ulcer. This operation has certain advantages over the Polya types, not least of these being the fact that many patients put on weight after the operation, whereas it is uncommon for a patient to do so following the Polya operation.

Vagotomy has no place at all in the treatment of gastric ulcer, nor have the old operations of local excision of the ulcer.

Should the ulcer at the time of operation be considered malignant, total gastrectomy must be performed if possible.

SUMMARY

Various etiological factors which have been proved to play an important part in the genesis of peptic ulcer are discussed.

The indications for surgery in the treatment of gastric and duodenal ulcer and their complications are given, followed by a brief note on the operative procedures in use to-day for the treatment of these conditions.

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VERENIGINGSNUUS : ASSOCIATION NEWS

SUIDWES-AFRIKA-TAK

VERGADERING VAN DIE SUIDWES-AFRIKA-TAK WAT OP 13 DESEMBER 1950 GEHOU WAS

Die Voorsitter en sewe ander lede was teenwoordig. Die Voorsitter het verwys na die afsterwe van dr. T. Eggers, en die lede versoek om op te staan om die gedagtenis van 'n gewaardeerde kollega te eer.

Dr. McRobert het die toegewings uiteengesit wat verkry is deur die onderhoud van 'n afvaardiging van die Distriksartsegroep met die Assistentsekretaris van Suidwes-Afrika.

Die moontlikheid van die oprigting in Windhoek van 'n laboratorium vir mediese diagnostiese toetse is weer bespreek, en daar is besluit om die saak voor die Uitvoerende Komitee te lê.

Uit bespreking het dit geblyk dat die vooruitsigte op die verwesenliking van die begeerte na 'n sentrale hospitaal as 'n opleidingsentrum vir verpleegsters in Windhoek baie gering was.

Drie nuwe lede is in die Tak verwelkom, en 'n afskeidsgroet is aan prof. Campbell gestuur, wat uit die diens van die Suidwes-Afrika-administrasie tree.

* * * *

Ons wens dr. en mev. J. G. Landsberg (née van Rooyen) van Karasburg geluk met die geboorte van 'n flinke seun op 23 November 1950.

J. E. Fischer,
Eresekretaris.

15 Desember 1950.

PASSING EVENTS

Dr. I. Sacks of Bloemfontein, accompanied by his wife, is at present in the United Kingdom doing post-graduate work. He expects to be back in Bloemfontein towards the end of April 1951.

Recently Dr. and Mrs. Sacks were present at the graduation of their son Neville at Aberdeen University, as M.B., Ch.B. Dr. Neville Sacks also holds the degree of B.Sc. (U.K.D.V.S.) and is remaining on to do his internship year at the Royal Infirmary, Aberdeen.

HISTORY OF MEDICINE

Prof. Douglas Guthrie, Professor of the History of Medicine at the University of Edinburgh, will lecture at 8.15 p.m. in the Physiology Lecture Theatre, Medical School, Mowbray, on 17 January 1951.

Prof. T. B. Davie, Principal of the University of Cape Town, will be in the chair. The meeting is being held under the joint auspices of the Medical Association of South Africa, the University of Cape Town and the Cape Town Post-Graduate Medical Association.

All interested are invited to attend.

* * * *

Jean Leslie, the daughter of Drs. A. L. G. and Mary M. Thomson of Idutywa, Transkei, was married on 9 December 1950 to George Boswell Napier of Tettenhall, Staffordshire, at Christ's Church, Lancaster Gate, London, W.2.

* * * *

Dr. Alan Thal, who graduated from the University of Cape Town last year, and who has completed his year of internship at the New York Hospital, has been appointed as intern in the Surgery Department of the Johns Hopkins Hospital, and will be working under Dr. Blalock.

COMMITTEE OF INQUIRY—BLOOD TRANSFUSION SERVICES

(Government Notice No. 3115 dated 15 December 1950)

The Honourable the Minister of Health has appointed a committee to inquire into the whole question of blood transfusion services, in all its aspects, in the Union, to report—

(a) whether such services are adequate for the present needs of the Union;
(b) whether it is desirable to extend such services on a national basis;
(c) on the relationship of such services to the Department of Health; and
(d) on the best methods of providing the necessary facilities and for administering and financing such services;
and to make recommendations regarding any statutory or other changes relative to any of the above aspects or any other matters relating thereto which the committee may consider necessary or desirable. The committee should take special cognisance of the recent developments in connection with the Rh factor and the use of blood plasma substitutes, with particular reference to the effect of these developments on the future of blood transfusion services.

The committee consists of the following members:—
Dr. J. N. W. Loubser (Chairman), Prof. L. J. te Groen, Prof. I. W. Brebner, Dr. B. M. Clark, Brig. E. Williamson, *C.B.E.*, Prof. H. Greenwood, with Mr. H. J. Adams, Chief Clerk, Department of Health, acting as Secretary.

UNIVERSITY OF CAPE TOWN: FACULTY OF MEDICINE

EXAMINATION RESULTS: 1950

Degree of Master of Surgery

Pass. Theunis Coetzee, M.B., Ch.B. (Subject of Thesis: *Carcinoma of the Prostate*).

Degree of Bachelor of Medicine and Bachelor of Surgery

Noel Henry Aldridge; Gerald Israel Anstey; Marius Stephanus Barnard; James Stansfeld Barnes, M.A.(S.Af.) (distinction in third professional examination); Prudence Mary Barrett; Russell Kenderdine Beardmore; Francis John Bennett; Reuben Michael Berelowitz; Maurice Berger; Harry Xavier Berning; Alicia Sheila Bernstein; Michael James Andrew Blanckenberg; Ary Blesovsky; Andries Petrus Blignault, M.A.(Stell.), M.Ed.(S.Af.); Aaron Bloch; John Botha; Phyllis Louisa Botha; William Gerard Bowes; Gustavus Olaf Wilder Derrick Howard van Someren Boyd; Henry Charles William Boyd; James Clifford Brown; Evert Johannes Cilliers, B.A.(Stell.); Marjorie Harriett Cohen; Cecil Berl Collins; Cecil John Tainton Craig; Thornton Heath Crouch; Harry Lloyd Fairbridge Currey; Harry Daitsh; David Davies; Bennie de Lange; Robert Graham Drummond; Seymour Dubb; Dale Miller du Toit; Francois Daniel du Toit; Robert Percival Dyer (distinction in first, second and third professional examinations and degree with second-class honours); Grisha Edelstein; Isaac Edelstein; Constant Eksteen; Edna Arnoldia Eksteen; Arthur Wellesley Falconer; Frederick George Feinstein; Basil Eric Talbot Fergus; Kenneth Henri Field; Neville Peter Guest Fischer, B.Sc.; Benjamin Frumer; Theodore Germond; Kingsley Dell Gill; Samuel Aaron Ginsberg; Hymie Gordon, B.Sc.; Jacoba Sophia Griffiths; Cecil John Hazlett Hagberg; Joseph Oftebro Harle; Anthony Moyese Henderson, B.Sc.(S.Af.); Arthur William Brookes Heywood; Peter Robert Skey Hodgson; Johannes Jacob Hofmeyr; Neville Chater Hopkins; Isaac Jach, B.Sc.; George Neville Paul Jackson; David Jacobson; Israel Jaffe; Robert James Douglas Jamieson; Frieda Elma Joffe; Catharina Josina Joubert; James de Villiers Kachelhoffer; Barny Kahanovitz; Arthur Charles Keast; Ailie Gordon Key; Hieronymus van Praag Koch; Joan Hildegarde Kohlberg; Ronald Ellis Kottler; Francois Pieter Stephanus le Roux, M.Sc.(Stell.); David Wilfried Levy; Vernon Benzion Liberman; Hyman Lidsky; Fay Leonard Liesching; Paul Leonard Leisching; Johanna Dorothea Louw, B.A.(S.Af.); Peter de Villiers Maasdorp; Daphne Miller McKenzie; Sammy Meltz; David Mirman; Raymond Thomas Mossop; Johannes Albertus Myburgh (distinction in first, second, third and final professional examinations and degree with first-class honours); Eugene Charles Neser (distinction in first and third professional examinations and degree with second-class honours); Robin Milman Newbery; Pamela Paterson; Pauline Charmian Paterson; Mary Elizabeth Philip; John Dealtry Pickford; Ottilie Pollak; Andrew Graeme Pollock; Stanley John Powell; Jan Albertus Pretorius, B.A.(Stell.); Clifford James Rauch; Christopher Petrus Retief (distinction in first professional examination); Maurice Gerald Rogoff; Edmund Francois Barclay Rose; Pierre-Paul Rouvroy; Lionel Aaron Sarembock; William Arthur Schmidt; Frederick John Schofield; Joseph Bernard Selkon; Barry Shandling; Douglas Hoseason Shennan; John Conrad Silberbauer; George Arthur Simons; William Gaines Slate; Andrè Odendaal Smit; Frederick David Smit; Oloff Nicolaas Rees Smit, B.A.(Stell.); Arthur Joseph Smith; Basil Solomon; Michael Creagh Stevens; Clive Lindsay Strauss; Gabriel Theron; Douglas Theophilus Thompson, B.A.(S.Af.); Melt van der Spuy; Johannes Jacobus van Heerden; Cornelius Tobias van Schalkwyk; Michael Gerhardus van Schalkwyk; David Jacobus Viljoen; Thomas James Vivian Voss; James Clifford Walsh; Cyril Waynik; Hyman Weiskopf, B.Sc.; Renate Westphal; Charles Wheeler; Anthony Michael Craven Whitaker; Ian James Spencer Wright; John Henry Youngleson.

SCHOLARSHIPS AND MEDALS: DECEMBER 1950

University Council Gold Medal: For the most distinguished graduate in medicine: Johannes Albertus Myburgh.

Barnard Fuller Prize: For the best student who qualifies for M.B., Ch.B. with first-class honours: Johannes Albertus Myburgh.

Dowie Dunn Memorial Prize: For the best student in paediatrics: Robert Percival Dyer.

Scholarships: On the result of the M.B., Ch.B. Examination: University Council Scholarship (£150 for one year): Johannes Albertus Myburgh.

AMPTELIKE AANKONDIGING

FEDERALE RAAD

Op die Vergadering van die Federale Raad van die Vereniging wat te Johannesburg op 15 Oktober 1950 gehou is, is formele erkenning en goedkeuring aan die volgende Mediese Hulpverenigings verleen:—

(a) African Explosives Medical Aid Society (Jhb), Posbus 1122, Johannesburg.
(b) Safmarine Medical Aid Society, Posbus 2171, Kaapstad.
(c) University of the Witwatersrand, Johannesburg, Staff Medical Aid Fund, Milner Park, Johannesburg.
(d) Hubert Davies Johannesburg Staff Medical Aid Society, Posbus 1386, Johannesburg.
(e) Reckitt & Colman Medical Aid Society (South Africa), Posbus 1097, Kaapstad.
(f) East London Municipal Employees Medical Aid Society, Posbus 134, Oos-Londen.
(g) Alex. Aiken & Carter Medical Benefit Society, Posbus 2636, Johannesburg.
(h) Northern Medical Aid Society, Posbus 3437, Johannesburg.
(i) Wright Boag & Head Wrightson (Pty.) Ltd. Sick Benefit Fund, Posbus 183, Benoni.
(j) Norwich Union Life Insurance Society, Norwich Uniongeboue, St. Georgestraat, Kaapstad.
(k) Natal Coal Owners' (Durban Staff) Medical Aid Society, 5de Vloer, Whytock-geboue, Smithstraat, 397, Durban.
(l) Natal Estates Limited, 400, United-geboue, Smithstraat 329, Durban.

A. H. Tonkin,
Mediese Sekretaris.

Mediese Huis,
Waalstraat 35,
Kaapstad.
18 Desember 1950.

OFFICIAL ANNOUNCEMENT

FEDERAL COUNCIL

At the meeting of the Federal Council of the Association held in Johannesburg in October 1950, formal recognition and approval was afforded to the following Medical Aid Societies:—

(a) African Explosives Medical Aid Society (Jhb), P.O. Box 1122, Johannesburg.
(b) Safmarine Medical Aid Society, P.O. Box 2171, Cape Town.

(c) University of the Witwatersrand, Johannesburg, Staff Medical Aid Fund, Milner Park, Johannesburg.
(d) Hubert Davies Johannesburg Staff Medical Aid Society, P.O. Box 1386, Johannesburg.
(e) Reckitt & Colman Medical Aid Society (South Africa), P.O. Box 1097, Cape Town.
(f) East London Municipal Employees Medical Aid Society, P.O. Box 134, East London.
(g) Alex. Aiken & Carter Medical Benefit Society, P.O. Box 2636, Johannesburg.
(h) Northern Medical Aid Society, P.O. Box 3437, Johannesburg.
(i) Wright Boag & Head Wrightson (Pty.) Ltd. Sick Benefit Fund, P.O. Box 183, Benoni.
(j) Norwich Union Life Insurance Society, Norwich Union Buildings, St. George's Street, Cape Town.
(k) Natal Coal Owners' (Durban Staff) Medical Aid Society, 5th Floor, Whytock Building, 397 Smith Street, Durban.
(l) Natal Estates Limited, 400 United Buildings, 329 Smith Street, Durban.

A. H. Tonkin.
Medical Secretary.

Medical House,
35, Wale Street,
Cape Town.
18 December 1950.

REVIEWS OF BOOKS

THE BRITISH ENCYCLOPAEDIA OF MEDICAL PRACTICE

The British Encyclopaedia of Medical Practice. In 12 volumes + Index. Second Edition. (Volume 2: pp. 711 + xiii + index. 66s. per volume.) South African Publishers: Butterworth & Company (Africa) Limited, 1 Lincoln's Court, Masonic Grove, Durban.

Contents: 1. Aphasia (Macdonald Critchley). 2. Aphthous Fever (Reginald Lovell). 3. Apoplexy (E. A. Blake Pritchard). 4. Appendicitis (V. Zachary Cope). 5. Apraxia (Macdonald Critchley). 6. Argyll Robertson Pupil (J. Purdon Martin). 7. Arrhythmias (T. Jenner Hoskin). 8. Arterial Disease and Degeneration (C. E. Lakin). 9. Arthritis—Acute (C. B. Perry). 10. Arthritis—Ankylosing Spondylitis (William Tegner). 11. Arthritis in Children (Alan Moncrieff). 12. Arthritis—Menopausal (Francis Bach). 13. Arthritis—Osteoarthritis (Matthew B. Ray). 14. Arthritis—Rheumatoid (W. S. C. Copeman). 15. Arthropods and Disease (R. M. Gordon). 16. Ascariasis (F. M. B. Allan). 17. Ascites (G. F. Beaumont). 18. Aspergillosis (Sir Henry Cohen). 19. Asphyxia (G. E. Stephenson). 20. Asphyxia in Childhood (Norman B. Capon). 21. Asthma (Frank Patrick Lee Lander). 22. Astigmatism (F. A. Williamson-Noble). 23. Ataxy (F. M. R. Walshe). 24. Athetosis (J. Purdon Martin). 25. Athletics (Sir Adolphe Abraham). 26. Athletic Injuries (W. E. Tucker). 27. Atomic Energy (J. F. Loutit). 28. Aviation Medicine (Sir Harold Whittingham). 29. Backache (William S. Tegner). 30. Balanitis and Balano-Posthitis (Brevet-Col. I. W. Harrison). 31. Bartonellosis (Sir Philip Manson-Bahr). 32. Bedsores (R. J. McNeill Love). 33. Bell's Paralysis (Anthony Feiling). 34. Beri-beri (Sir John Megaw). 35. Bilharziasis (N. Hamilton Fairley). 36. Biliousness (F. Avery Jones). 37. Birth Palsies—Intracranial Injuries in the Newborn (S. Nevil). 38. Blackwater Fever (Brian Maegraith). 39. Bladder Diseases (Kenneth Walker). 40. Blast Injuries (Sir Cecil Wakeley). 41. Blastomycosis (G. B. Dowling). 42. Blindness (H. B. Stallard). 43. Blood Examination (C. J. C. Britton). 44. Blood Pressure, High and Low (A. A. Fitzgerald Pedi). 45. Blood Transfusion (F. A. Knott). 46. Boils and Carbuncles (F. Ray Bettley). Index.

With this second volume, *The British Encyclopaedia of Medical Practice* gets into its stride. The range of topics is, of course, determined by alphabetical exigencies, but the modern reader will be particularly interested to know that this volume includes chapters on Atomic Energy and Aviation Medicine. Copeman's account of rheumatoid arthritis refers to the role of the adrenal cortex in the section dealing with Aetiology and has nothing to say about Cortisone or ACTH in the section dealing with Treatment. Copeman recognizes that remarkable remissions in cases of active rheumatoid arthritis can be produced by Cortisone but draws attention to the fact that although the effect of infection may have been exaggerated in the past, it still cannot be ignored completely. He also points out that we are very likely not dealing with an adrenal cortex deficiency in the crude sense, because ACTH produces identically beneficial effects. It is difficult to understand his statement, however, that ACTH stimulates the adrenal *via* the pituitary gland. It is obviously acting as a substitute stimulus to the adrenal rather than as a stimulus to the pituitary.

The section on Asphyxia has been prepared by an expert in medical jurisprudence. It is a comprehensive and authoritative treatment of the subject, fitting for inclusion in an encyclopaedia. Currency is, however, given to the statement that the prolonged fluidity of the blood is a characteristic sign of asphyxia. The fluidity of the blood *post mortem* depends upon the development of fibrinolysin; the post-mortem interval is, therefore, important in determining whether the pathologist will find a fluid condition of the blood or not. Mole (J. Path. Bact., 1948, **60**, 413) has surveyed the whole problem very adequately and his views should certainly influence modern accounts of this subject.

The section dealing with blood pressure gives a most adequate account of hypertension and a critical assessment of the Smithwick operation. Particularly interesting is the extremely well-informed account of hypotension, including the orthostatic variety, which may produce considerable incapacitation in relation to the menstrual cycle as well as during the early months of pregnancy.

The illustrations have achieved a supreme degree of excellence and the colour photographs leave nothing to be desired. The volume is most attractively produced and is a worthy medium for the presentation of the mass of authoritative data which this encyclopaedia very clearly will provide.

LIGHT THERAPY

Light Therapy: A Monograph in American Lectures in Physical Medicine (No. 57 in the American Lecture Series). By Richard Kovacs, M.D. (Pp. 112 + viii. With 28 figures. 16s. 6d.) U.S.A.: Charles C. Thomas; England: Blackwell Scientific Publications Limited. 1950.

Contents: 1. The History of Light Therapy. 2. Physics of Radiant Energy. 3. Infrared and Luminous Radiation. 4. Ultraviolet Radiation. 5. Bibliography. 6. Index.

This monograph by the professor of Physical Medicine at the New York Polyclinic is a clear and concisely written work which is eminently suitable for the general practitioner or medical student.

The reader is presumed to have an elementary knowledge of the physics of light and heat although the physical data are presented in a simplified and acceptable form. A good deal of the subject matter is to be found in Kovac's more comprehensive book *Electrotherapy and Light Therapy*.

The book under review is balanced and clear, and conservative indications are given for the various physical modalities described.

It is a pity that the illustrations of the apparatus are not in diagrammatic form since nothing is gained by looking at the glossy photographs of the actual apparatus. Many references are indicated in the text and there is a substantial list of reference for further reading.

The book is well presented and substantially bound.

THE LINACRE LECTURE

Humanism, History, and Natural Science in Medicine. By F. M. R. Walshe, M.D., D.Sc., F.R.S. (Pp. 29. 1s. 6d.) Edinburgh: E. & S. Livingstone Limited. 1950.

It is always a pleasure to read Dr. Walshe, particularly when he writes about the intellectual foundations of medicine. This pamphlet makes available a scholarly and provocative lecture given at St. John's College, Cambridge, and is itself a bright example of the eloquence, wisdom and contemplativeness which Dr. Walshe would have restored to the practice of medicine.

In his Harveian Oration in 1948 Dr. Walshe postulated that the place of medicine is within the body of the natural sciences. In the present lecture he submits that medicine also extends into the field of historical science and has in addition qualities of humanism that the natural sciences can scarcely claim. The clinical examination of a patient demands from the physician not only knowledge of the newest techniques but also reflection and critical thought, and an ability to detect patterns and interpret observations logically.

The practice of medicine flourishes most when doctors think most highly of their functions. One receives gratefully Dr. Walshe's attempts to restore the association that medicine once had with the humanities.

PRACTICE OF MEDICINE

The Practice of Medicine. By Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D.Sc. (Pp. 1558 + xx. With 518 illustrations including 50 in colour. £5 14s. 9d. 5th ed.) St. Louis: C. V. Mosby Company. 1950.

Contents: 1. An Introduction to the Practice of Medicine. 2. Diseases of the Nasopharynx and Mouth. 3. Specific Infections of the Nasopharynx and Mouth. 4. Diseases of the Larynx and Bronchial System. 5. Diseases of the Lungs. 6. Diseases of the Lungs (Contd.) 7. Diseases of the Circulatory System. 8. Diseases of the Serous Membranes, Mediastinum and Diaphragm. 9. Diseases of the Hematopoietic System. 10. Diseases of the Gastro-intestinal Tract. 11. Diseases of the Liver and Bile Passages. 12. Diseases of Nutrition. 13. Diseases of Metabolism. 14. Diseases of the Ductless Glands. 15. Diseases of the Nervous System. 16. Psychosomatic Medicine. 17. Diseases of the Locomotor System. 18. Diseases of the Urinary System. 19. Infectious Diseases. 20. Chemotherapy and Antibiotics. 21. Diseases due to Allergy. 22. Diseases due to Abnormal Environments. 23. Diseases due to Chemicals and Drugs.

The previous edition of this textbook by the former Professor of Medicine of McGill University appeared in 1945. The many important changes in medicine since that time have been described. In accordance with one of the major re-orientations of recent years, the section on psychiatry has been replaced by a chapter on psychosomatic medicine. The epoch-making discoveries in the field of chemotherapy have devoted to them a special section of the book.

This is eminently a clinical book. Symptoms are given particular prominence. The pathological basis of symptoms is everywhere stressed, and the bedside recognition and interpretation of clinical signs is described with a sustained interest and lucidity rare in large textbooks.

In spite of its imposing size, which is due to the wide range of subjects treated, the book contains a minimum of theoretical discussion. Indeed, it may be an objection that many recent advances in various fields do not receive the attention they deserve. The book is thus not to be considered as a work of reference. It is obviously intended not for tasting or for swallowing, but (in the words of Bacon) 'to be chewed and digested'. The book reads easily, and what it lacks in depth it gains in the extent of information offered. Illustrations are profuse and valuable, obviously collected with great care over a long period of time. The student introduced to this book is a fortunate man; his knowledge will be extensive and gained without tedium.

The author has retained the chapter on neurological disease which was written by the late Dr. Petersen; but this section needs revision. Although it is mentioned that papilloedema may be measured with the lenses of the ophthalmoscope, the reader is not told how to do so. The very important, interesting and controversial subject of aphasia is dismissed in a page. The new phylogenetic investigations and morphological concepts of the cerebellum are not mentioned.

VENEREAL DISEASES

A Text-Book of Venereal Disease. By R. R. Willcox, M.B., B.S., M.R.C.S., L.R.C.P. (Pp. 439. With 154 figures. 32s. 6d.) London: William Heinemann Medical Books. 1950.

Contents: 1. Venereal Disease and Anatomy. 2. Diagnosis of Gonorrhoea. 3. Gonorrhoea in the Male. 4. Complications of Gonorrhoea in the Male. 5. Gonorrhoea in the Female. 6. Gonorrhoea in the Child. 7. Non-Gonococcal Discharges in the Male. 8. Non-Gonococcal Discharge in the Female. 9. Diagnosis of Syphilis. 10. Early Acquired Syphilis (1) Primary Syphilis. 11. Early Acquired Syphilis (2) Secondary Syphilis. 12. Treatment of Early Acquired Syphilis. 13. Latent Syphilis and Late Syphilis of the Skin and Mucous Membranes. 14. Late Osseous and Late Visceral Syphilis. 15. Cardiovascular Syphilis. 16. Neurosyphilis. 17. Congenital Syphilis. 18. Prognosis of Syphilis. 19. Yaws and other Diseases Resembling Syphilis. 20. Chancroid, Lymphogranuloma Venereum and Granuloma Inguinale. 21. Other Conditions Commonly Encountered in Venereal Diseases Clinics. 22. The Sulphonamides. 23. The Antibiotics. 24. The Arsenicals. 25. Bismuth, Mercury and Iodides. 26. Prophylaxis and Venereal Diseases Control. 27. Details of Technique. Index.

In the past decade the treatment of venereal diseases has changed dramatically and the author has included in this textbook the most up-to-date information about the antibiotics and the sulfa drugs.

The wide experience he has had in West Africa and the Rhodesias has resulted in an excellent chapter on the allied conditions of syphilis, yaws, bejel, pinta and njovera, conditions which almost certainly occur to some extent in our non-European population but are often misdiagnosed. The numerous and excellent illustrations of the different manifestations of venereal disease in Natives are most useful.

There is a tendency in most textbooks to gloss over some of the more difficult problems of the practice of venereal diseases, such as non-specific urethritis and vulvo-vaginitis. It is a pleasure to see that Dr. Willcox has given a most workmanlike description of these conditions. In passing, this reviewer can confirm that numerous cases of non-specific urethritis in Natives, in the Transvaal at any rate, are due to bilharzia.

Written in a simple and pleasant style, this textbook should command a ready sale. It is strongly recommended for students and general practitioners, particularly those dealing with venereal disease in the Native, and the specialist also will find much of interest.

FACIAL PARALYSIS

Facial Paralysis. A Treatise on a Clinical Classification of Paralysis of the Facial Nerve. By J. Parkes Findlay, M.B., Ch.M. (Pp. 47 with illustrations. 17s. 6d.) Sydney: Angus & Robertson Ltd. 1950.

Contents: 1. Introduction. 2. Anatomy of the Facial Nerve. 3. Variations. 4. Examination. 5. Symptomatology of Facial Paralysis. 6. Diagnosis. 7. Geniculate Facial Paralysis. 8. Neuritic Facial Paralysis. 9. Treatment of Geniculate and Neuritic Facial Paralysis. 10. Vascular Occlusion Facial Paralysis. 11. Treatment of Vascular Occlusion Facial Paralysis. 12. Traumatic Facial Paralysis. 13. Prognosis. 14. Bibliography.

This little book is attractively produced on good paper. Its main thesis is the classification and differential diagnosis of facial palsies of different aetiologies and prognosis and treatment based on such a differentiation.

The author separates geniculate facial paralysis, always accompanied by pain and herpes zoster and neuritic facial palsy, which is secondary to focal sepsis and painless. He considers that these two types invariably clear up completely, while the third group, due to occlusion of blood vessels supplying the facial nerves in the Fallopian canal, requires surgical decompression, being otherwise associated with a bad prognosis. Proof of the vascular origin of the latter group seems somewhat slender, especially since no microscopic investigation was possible, but the attempt to diagnose from the start those cases which need surgical treatment is important, and will need further consideration, whatever their aetiological background.

RADIOTHERAPY IN MALIGNANT DISEASE

The Results of Radium and X-ray Therapy in Malignant Disease. Being the Third Statistical Report from the Radium Institute, the Christie Hospital and Holt Radium Institute, Manchester. Compiled by Ralston Paterson, Margaret Tod and Marion Russell. (Pp. 166. 10s. 6d.) Edinburgh: E. & S. Livingstone Limited. 1950.

Contents: Part I. 1. General Survey and Discussion of the Material for the Report. 2. Malignant Disease—All Cases Referred Showing Disease Classification. 3. Malignant Disease—New Cases Only. All Sites. *Part II.* 4. Scientific Report with Comparative Analyses of the Various Techniques Employed. *Part III.* 5. Ten-Year-Report of Results of Treatment During Years 1934 to 1938. 6. Conclusion. 7. Relevant Publications by Members of the Staff.

Once again the Christie Hospital and Holt Radium Institute, Manchester has set the standard for others to follow. This Third Statistical Report, while of the same pattern as its predecessor, is greatly enhanced by the introduction of the 'Corrected survival rate' and its addition to each table. Detailed instructions and tables prepared by the Statistical Office of the General Register Office are included to guide others in the construction of 'Corrected survival rates'.

The correction tables are designed to make due allowance for age and the probability of not dying from any cause within five years.

The value of this report lies not only in the method of presentation, but also in its inclusion of five and ten year statistical surveys of cases treated between the periods 1940

to 1944 and 1934 to 1938, with comparative analyses of the various techniques employed and a very valuable commentary on each section of the report.

The book reviews statistically in the five-year survey the results of the treatment of 11,685 treated cases together with 1,834 untreated cases, and in the 10-year surveys the results of treatment in some 4,655 cases. In so doing the results of treatment obtained in one of the world's leading institutes are made readily accessible.

The report should be carefully studied by all whose work brings them into contact with patients suffering from malignant disease or with hospitals or allied organizations directly concerned with cancer therapy or research. Particularly is it recommended to those in authority whose function it is to ensure the adequate hospitalization and treatment of patients.

PHYSICIAN'S HANDBOOK

Physician's Handbook. By M. A. Krupp, M.D., N. J. Sweet, M.D., E. Jawetz, Ph.D., M.D. and C. D. Armstrong, M.D. (Pp. 380. $2.50. 6th ed.) Palo Alto: University Medical Publishers. 1950.

This sixth edition will be welcomed by all those acquainted with it. The title is modest: the shape and size convenient. Between its covers there is an amazing wealth of information likely to be of use to the undergraduate student, the candidate for the M.R.C.P., the general practitioner and physician alike.

There are numerous normal standards, useful information relating to practical procedures, an informative chapter on fluid and electrolyte balance and intravenous therapy, a guide to diets, emergency therapeutic measures and much other data too extensive to enumerate.

Much care and effort has obviously gone into the preparation of this little book and all those concerned are to be warmly congratulated on the result.

ENDOCRINOLOGY

Textbook of Endocrinology. Edited by Robert H. Williams, M.D. (Pp. 793 + xii, with 168 illustrations. £4 5s.) Philadelphia and London: W. B. Saunders Company. 1950.

Contents: 1. General Principles of Endocrinology. 2. Pituitary. 3. Thyroid. 4. The Adrenals. i. Chronic Adrenal Hyperfunction. ii. Adrenal Cortical Insufficiency. 5. The Testes. 6. The Ovaries. 7. The Pancreas and Diabetes Mellitus. 8. Diseases of the Parathyroid Glands. 9. Influence of Endocrine Glands upon Growth and Development. 10. Neuro-endocrine and Psychodynamic Aspects of the Endocrinopathies. 11. Obesity. 12. Laboratory Diagnostic and Assay Procedures.

Dr. Williams (who has edited and partly written this very good book on the ductless glands) and his collaborators are well-known clinicians and research workers in the United States who have been associated with many of the advances in endocrinology. The book has been written for the practising doctor and as is now usual in this branch of medicine the anatomy, the physiology and the biochemistry of the various glands are briefly discussed at the beginning of each chapter so that the reader can approach each section in the appropriate frame of mind, viz. with a proper understanding of the intricacy of endocrine physiology and of the complicated gland inter-relationships.

It has always puzzled the reviewer why the average practitioner resents the infrequency of clear-cut clinical conditions in endocrinology. The delicate balance of the glandular system of necessity determines that, when one gland is diseased, one or more other members of the system react and help to produce signs and symptoms which complicate the clinical picture. This is reflected in treatment, because the problem is magnified here as so many of the preparations are inactive (*pace* the manufacturing chemists). In spite of these difficulties the several authors have succeeded in presenting a well-written and readily understood book, and some of the illustrations are beautifully produced and informative.

It is difficult to choose any particular subject to discuss. The chapter on diabetes is very good and the necessity to inject very large doses of insulin in diabetic coma is stressed. The value of the replacement of potassium in the intravenous infusion is not generally known, and more attention to this procedure may make all the difference to the outcome. In the treatment of thyrotoxicosis, iodine, propyl-thiouracil and radio-active iodine are all used, but surgery still has pride of place. ACTH and Compound E (Cortisone) are mentioned, but there is general agreement that both these substances are still very much in the experimental stages. A chapter on obesity is included. The treatment is, obviously, still based on two manoeuvres:—wave the hands in front of the body to ward off the second helping; and grip the edge of the table hard when offered any food one likes.

This is a good book and worth having for reference in daily practice.

PRACTICAL HAEMATOLOGY

Practical Haematology. By J. V. Dacie, M.B., B.S. (Lond.), M.R.C.P. (Lond.). (Pp. 172 + vii. With 13 illustrations. 10s. 6d.) London: J. & A. Churchill Limited. 1950.

Contents: 1. Blood Samples for Clinical Haematology. 2. Basic Haematological Techniques I. 3. Basic Haematological Techniques II. 4. Measurement of Red Cell Diameters. 5. Supplementary Staining and Optical Techniques. 6. Bone Marrow Biopsy. 7. Laboratory Methods Used in the Investigation of the Haemolytic Anaemias. 8. Laboratory Methods used in the Investigation of Patients Suffering from Haemorrhagic Disorders. 9. Blood Groups and the Laboratory Aspects of Blood Transfusion. 10. Miscellaneous Investigations. 11. Appendices.

This little book, which according to the author's preface is primarily intended for the laboratory technician, contains so much useful information that it should find a wider appeal. The medical student and the intern endeavouring to acquire proficiency in haematological techniques will here find clear and concise descriptions of standard methods with well-considered judgment of their purpose and value. The clinician asking for a 'full blood count' or other time-consuming routine investigations will be reminded of the considerable errors inherent in such investigations, and may realize the abuse of the overburdened laboratory which takes place to-day. He will find much common sense in the interpretation of results.

Finally, as the author intended, the technician's routine work will gain in interest by frequent references to the notes in this volume.

The specialized haematologist will probably retain his own methods and systems, but he will nevertheless find Dr. Dacie's opinions stimulating and satisfactory.

The book is well produced, pleasantly free from errors, and attractively cheap.

DISEASES OF THE EAR, NOSE AND THROAT

Common Diseases of the Ear, Nose and Throat. By Philip Reading, M.S., F.R.C.S. Pp. 288 with 2 coloured plates and 37 text figures. 21s.) London: J. & A. Churchill Ltd. 1950.

Contents: 1. Otoscopy. 2. The Middle Ear Cleft. 3. The Temporal Bone. 4. The Eustachian Tube. 5. Acute Infections of the Middle Ear Cleft. 6. Treatment of Acute Otitis Media. 7. Acute Mastoiditis. 8. Chronic Infections of the Middle Ear Cleft. 9. Pinna and External Auditory Meatus. 10. Vertigo. 11. Deafness. 12. Examination of the Nose. 13. Anatomy of the Nose. 14. Injury to the Nose and Epistaxis. 15. Functions of the Nose. 16. Acute Infections of the Nose. 17. Chronic Infections of Nose and Sinuses. 18. Intracranial Infections. 19. The Larynx. 20. Laryngeal Functions and Their Derangements. 21. Laryngoscopy. 22. Infection of the Larynx. 23. Narrowing of the Laryngeal Inlet. 24. The Lymphoid Tissue of the Throat. 25. Diseases of the Throat. 26. Tonsillectomy. 27. Deglutition and Dysphagia. 28. New Growths. 29. The Use of Penicillin and the Sulphanomides in Diseases of the Ear, Nose and Throat. Index.

This book has been confined to essential facts and has been written for students and medical practitioners in order to simplify the many problems met in general practice.

Operative techniques have largely been eliminated, but complications of certain common operations, like tonsillectomy, have rightly been described at length. Detailed anatomical and physiological facts have been omitted without detracting from the value of the book.

The chapter on Vertigo, describing the physiology of the labyrinth, often a difficult subject to explain and even then to understand, has been simplified commendably and should meet with general approval.

Important signs and symptoms have been numbered suitably and stressed in bold type, thus eliminating considerably delay for the busy practitioner or student who has not the time to

spend reading through many pages in order to look for a few important facts.

This useful little book has been well planned and written, and can be recommended to all medical men intent on furthering their knowledge of an interesting and at times difficult branch of surgery.

ILLINGWORTH'S SURGERY

A Short Textbook of Surgery. By C. F. W. Illingworth, *C.B.E.*, M.D., Ch.M., F.R.C.S. (Ed.) (Pp. 676 + viii. With 13 plates and 233 text-figures. Fifth edition 30s.) London: J. & A. Churchill Limited. 1950.

Contents: 1. Safety Factors in Surgery. 2. Healing and Repair of Wounds. 3. Wound Infections. 4. Actinomycosis. 5. Tuberculosis. 6. Syphilis. 7. Gonorrhoea. 8. Shock and Haemorrhage. 9. Burns and Scalds. 10. The Skin and Subcutaneous Tissues. 11. The Muscles, Tendons, Tendon Sheaths and Bursae. 12. The Peripheral and Autonomic Nerves. 13. The Blood Vessels. 14. The Lymph Glands and Vessels. 15. Affections of Bones. 16. Affections of Joints. 17. The Shoulder Girdle and Arm. 18. The Elbow Region. 19. The Forearm, Wrist and Hand. 20. The Hip and Thigh. 21. The Region of the Knee. 22. The Leg, Ankle and Foot. 23. The Skull and Brain. 24. The Spine and Spinal Cord. 25. The Eye, Ear, Nose and Throat. 26. The Face, Mouth, Tongue, Jaws. 27. The Neck. 28. The Thyroid and Parathyroid Glands. 29. The Larynx, Pharynx and Oesophagus. 30. The Breast. 31. The Thorax. 32. The Abdominal Wall and Hernia. 33. The Peritoneum. 34. Abdominal Emergencies. 35. The Stomach and Duodenum. 36. The Intestines. 37. The Rectum and Anus. 38. The Biliary Tract. 39. The Pancreas. 40. The Spleen. 41. The Adrenal Glands. 42. The Appendix. 43. The Kidney and Ureter. 44. The Bladder and Urethra. 45. The Male Genital Tract. 46. The Female Genital Tract. 47. Radiotherapy and Physiotherapy. Index.

Three years have elapsed since the previous edition, during which time this book has been revised thoroughly. Despite the rapid advances in surgery, the author has succeeded in keeping this book within its former limits and has included sections on pulmonary stenosis and portal hypertension. The chapter on affections of bones makes worth-while reading, and several excellent plates showing typical radiological appearances have been added.

For a book of this size, orthopaedics and conditions of the breast have been described fully. Prof. Illingworth, by writing in a simple way, by using descriptive headings and by avoidance of repetition, has written a book which will prove most popular with the undergraduate medical student.

This book is based on a vast knowledge of surgical pathology. We can, therefore, strongly recommend it to the student wishing to acquire a good general knowledge of surgery.

OPHTHALMOLOGY

Essentials of Ophthalmology. By Roland I. Pritikin, M.D., F.A.C.S., F.I.C.S. (Pp. 561 + xi, with 215 illustrations, including 18 subjects in colours. 60s.) Philadelphia, London, Montreal: J. B. Lippincott Company. 1950.

Contents: *Part I*: Fundamental Ophthalmology. 1. Anatomy and Development of the Eye and Adnexa. 2. Physiology of the Eye. 3. Examination of the Eye. 4. The Extra-Ocular Muscles. 5. Spectacles. 6. Industrial Ophthalmology.
Part II: Diseases of the Eye. 7. Diseases of the Lids, Lacrimal Apparatus, Conjunctiva and Sclera. 8. Diseases of the Cornea and Lens. 9. Diseases of the Uveal Tract. 10. Diseases of the Retina and the Optic Nerve. 11. Diseases of the Vitreous and Orbit and Glaucoma. 12. Anomalies and Ocular Manifestations of General Diseases. Index.

This is a handy and handsome volume. Beautifully printed in legible type, it is a credit to the American craftsmen who produced it.

Dr. Pritikin is ophthalmic surgeon to the Winnebago County Hospital. He has attempted to give a short, yet practical account of modern ophthalmic practice. He has achieved brevity, but, at times, at the expense of clarity. A short description of ocular anatomy and physiology is followed by a potted account of diseases of the eye.

Indicative of a point of confusion in ophthalmic nomenclature is the author's use of the term nyctalopia for night blindness and hemeralopia for day blindness. This is the reverse of the usual practice in English textbooks and contrary to the derivation of these words. While on the subject of terminology, the purist will not like the inclusion of syphilitic and tuberculous lesions of the retina under the heading of retinopathy.

The writer believes that uncorrected errors of refraction are a cause of blepharitis and chronic catarrhal conjunctivitis. This fable probably has no more foundation in fact than a tale by the brothers Grimm.

Dr. Pritikin appears to advocate medical treatment of cataract by courses of Dionine lasting 100 days and subconjunctival injections of mercury cyanide. This treatment is unlikely to be productive of any effect other than discomfort to the patient.

The chapter on Industrial Ophthalmology is interesting, particularly the section on compensation principles. A useful table gives the percentage loss of vision corresponding to various Snellen notations and the method of calculating industrial visual efficiency is described.

The many illustrations of equipment used in ophthalmic diagnosis are very good, but the book would have been the better for more pictures of fundus lesions and external conditions of the eye.

BRITISH SURGICAL TECHNIQUES

Techniques in British Surgery. Edited by Rodney Maingot, F.R.C.S. (Pp. 733 + xx, with 473 illustrations. £6 7s. 6d.) Philadelphia and London: W. B. Saunders Company. 1950.

Contents: *Part I*: Head, Neck and Spinal Column. 1. The Management of Head Injuries in Civil Life. 2. Spinal Tumours. 3. Surgery of the Thyroid Gland. 4. Parkinson's Disease: Radical Division of the Lateral Pyramidal Tract for Tremor.
Part II: Thorax. 5. Congenital Defects of the Heart. 6. Thymectomy for Myasthenia Gravis. 7. The Treatment of Empyema Thoracis. 8. Technique of Pneumonectomy. 9. Surgical Treatment of Pulmonary Tuberculosis. 10. Mammaplasty.
Part III: Abdomen and Pelvis. 11. Vagal Resection. 12. The Management of Acute Intestinal Obstruction. 13. Benign Strictures of the Rectum. 14. Cysts of the Epididymis (Spermatoceles). 15. Carcinoma of the Head of the Pancreas. 16. Surgical Aspects of Cardiospasm. 17. Surgery of Peptic Ulcer. 18. Hypospadias. 19. Aseptic Intestinal Anastomosis. 20. The Treatment of Inguinal Hernia. 21. Strangulated Femoral Hernia. 22. Synchronous Combined Excision for Carcinoma of the Rectum. 23. Radical Retropubic Surgery of the Prostate. 24. Stress Incontinence of Urine in the Female.
Part IV: Extremities. 25. Arthrodesis of Hip, Knee and Ankle. 26. Bone Transplants in the Treatment of Bone and Joint. 27. Recurrent Dislocation of the Shoulder. 28. Congenital Dislocation of the Hip. 29. Talipes. 30. Acute Infections of the Hand. 31. Nerve Suture. 32. Management of Senile and Diabetic Gangrene. Index of Subjects. Index of Authors.

Techniques in British Surgery presents the work of the best British surgeons, and includes a number of specially selected articles written by 29 leading surgeons and accomplished teachers in active practice. Consequently, it is difficult to single out any particular article for mention. Owing to the width of the field covered, this book will have the greatest appeal to the general surgeon.

Norman Tanner has written an excellent chapter accompanied by lucid diagrams on the *Surgery of Peptic Ulcers*. Having performed over 2,000 gastrectomies, he gives one a feeling of confidence in his technique. The Hoffmeister technique of anastomosing the cut end of stomach to the jejunum is used by the author and claims good results by this method. Not everyone, however, will agree with the use of continuous suturing recommended.

In no surgical book will a better description of subtotal thyroidectomy be found. The diagrams, which are magnificent, make the operation self-explanatory. The various steps in the operation are described in detail and can be followed readily. One cannot accept the author's view that tying of the inferior thyroid artery in continuity lessens the recurrence rate or is always necessary.

Cardiospasm, a difficult subject, has been well accounted for by Rodney Maingot.

For the urologist, plastic surgeon and orthopaedist, there are several subjects of interest.

The synchronous combined resection of the rectum, a description of which is difficult to obtain, is clearly described in this book.

The paper is of excellent quality, and the artists have to be congratulated on their excellent drawings. If this book is the forerunner of a similar series of popular articles, one can happily look forward to future publications by British surgeons.

MICROSCOPICAL TECHNIQUE

McLung's Handbook of Microscopical Technique. Edited by Ruth McLung Jones, Professor of Biology, Winthrop College, South Carolina. Pp. 790 + xix, with 157 illustrations. Third ed., revised and enlarged. $12.) New York: Paul B. Hoeber, Inc. 1950.

Contents: Part I. General Procedures and Information. 1. Basic Methods for Preparing Microscopical Slides. 2. Fixation and Fixatives. 3. Stains and Staining.
Part II. Special Procedures with Limited Application. 4. Methods of Cytology. 5. Methods of Embryology. 6. Methods of Histology. 7. Methods of Protozoology.
Part III. Special Prodcedures with General Application. 8. Methods for Study of Fresh Material. 9. Methods Applicable to the Study of Both Fresh and Fixed Materials. 10. Methods for Fixed Materials. Index.

In this book will be found gathered together information which otherwise is widely dispersed in a large number of books. It is essentially a book of reference wherein are contained the answers to the majority of questions which may be asked by workers who commonly use microscopes. Means of solving problems with regard to the preparation of specimens, and descriptions of the methods available for the examination of the finished preparation are set out.

The section on basic methods in the preparation of microscopical slides is very good, and could be profitably read by everyone during their early laboratory days, and indeed, by many with much longer periods to their credit.

Anyone particularly interested in recent developments in the microscopical art will find adequate descriptions and explanations of the centrifuge microscope, polarizing microscope, electron microscope and of fluorescence and phase microscopy together with a section on radio-autographic technique. Where these methods fit into laboratory practice is also discussed, and their respective limitations noted.

Very few days will pass in the laboratory when the book is not consulted, and it will be very few difficulties of technique which are not partially or completely solved through its pages. It should, therefore, be seen on the shelves of nearly all laboratories, and especially those working in the biological sciences.

HAY FEVER

Hay-Fever: A Key to the Allergic Disorders. By John Freeman, D.M. (Oxon.). (Pp. 321 + xx, with 71 illustrations. 42s.) London: Messrs. William Heinemann, Medical Books, Limited. 1950.

Contents: 1. Hay-Fever Itself. 2. On the Relationship Between Hay-Fever and all other toxic Idiopathies. 3. Causation in General, and the Fallacy of the Single Cause. 4. The Idiotoxin Cause of Toxic Idiopathies and how it may be Dealt With. 5. Idioceptor: The Allergic Sensitivity and How We May Deal With It. 6. Prophylactic Thoroughgoing Desensitization (P.T.D.) By Self-Inoculation. 7. 'Cause D.' Serous Leak. 8. Trauma: Tissue Damage and Localising Factor. 9. Emotions, Moods and Tensions. 10. Home Influence. 11. Further Considerations of Emotion. 12. 'Cause G.' The Bacterial Factor. 13. Exercises in Phylactology. 14. Vaccines and Pathophanes for the Toxic Idiopathies. 15. Specificity of Idiotoxic Antigens. Appendix. Index.

The Wright-Fleming Institute of Microbiology, recently so renamed in honour of these distinguished members of its staff, is the old Inoculation Department of St. Mary's Hospital, London. It is in this well-known laboratory-clinic that the activities in allergy described in this book had their birth and development. The book is the outcome of more than 40 years of work by Dr. Freeman in allergic conditions and, as such, is entitled to the attention of workers in the field who cannot fail to be interested in this distillate of a vast experience.

The work is neither a textbook nor a scientific treatise with hypotheses and reports of controlled experimental investigations. Freeman writes in an easy conversational style, backed by commonsense, wisdom and humour. The approach, however, is strikingly individualistic. There is little comment on the views or the work of other allergists; nor are there any references to the massive literature that has grown up with the intensive clinical and laboratory studies of allergy, particularly in America. The author's outlook, in a number of instances, would hardly be acceptable to other workers, e.g. his view that house dust has scant significance does not accord with that of most allergists who look upon this substance as having important specific allergenic properties.

The chapters on emotions, moods and tensions are worth reading in these days of the psychodynamic approach to allergy, not only because they corroborate so well other findings, but also because they reveal an immunologist's diversion, if not conversion, by the sheer weight of evidence, to the psychologist's viewpoint. Large numbers of brief, factual records are given, as well as a few elaborate case histories in support of the belief that emotional states may provoke allergic manifestations.

The techniques of skin testing and therapeutic desensitization are fully described and the methods of self-inoculation, developed in the author's clinic, are detailed. The importance of the bacterial factor in allergy is well brought out.

The book is handsomely produced and is satisfying to handle and to read.

MEDICINE 1950

The 1950 Year Book of Medicine (May 1949-May 1950). Edited by P. B. Beeson, J. B. Amberson, W. B. Castle, T. R. Harrison and G. B. Eusterman. (Pp. 819 with 136 figures. $5.00.) Chicago: Year Book Publishers, Inc. 1950.

Contents: 1. Infections. 2. The Chest. 3. The Blood and Blood-forming Organs. 4. The Heart and Blood Vessels and the Kidney. 5. The Digestive System.

Those who are familiar with previous editions of the *Year Book* will have recognized that it is no mere short-cut to a spurious familiarity with medical advances. The five sections of the book carry the firm imprint of an authoritative editorial hand. Each abstract is a neat and intelligent reflexion of the report it condenses, and is placed in proper perspective by critical comment.

It is a fair claim that the *Year Book* presents in an eminently readable and stimulating manner the notable advances in the practice of medicine during the past year. This is a commendable achievement, of great value to the practitioner who wishes to remain familiar with modern trends, even when confronted by the ceaseless industry of innumerable researchers.

There is small point in selecting for separate mention any particular aspect of the sound advances made since May 1949. Numerous abstracts are concerned with further achievements in the use of the antibiotic drugs, the considerable progress in treatment of chest diseases, and the surgical interest in cardiac conditions. Many will consider modest Dr. Eusterman's assertion that greater medical progress has been made in the past half-century than in the previous 200 years.

South African research is represented by Merskey's study of the 'non-leukaemic myeloses' and of the relationship of polycythaemia vera and myeloid leukaemia. Bull is reported on the conservative treatment of anuric uraemia. A reminder of the loss suffered in the death of Dr. Lionel Berk is a report of his work on the erythropoetic effect of cobalt blue.

ANKLE INJURIES

Injuries to the Ankle. By J. Grant Bonnin, M.B., B.S. (Melbourne); F.R.C.S. (England). (Pp. 412 + xvi with 399 figures. 1st edition. 63s.) London: William Heinemann, Medical Books, Limited. 1950.

Contents: 1. Introduction and Historical Survey. 2. Anatomy. 3. The Radiography of the Ankle Joint. 4. The Mechanism of Fracture of the Ankle. 5. The Individual Lesions. Introductory. 6. Ligamentous Injuries without Fracture. 7. Minor Fractures Associated with Ligamentous Injuries. 8. Diastasis of the Tibio-Fibular Syndesmosis. 9. Fractures by External Rotation Violence. 10. Fractures by Abduction Violence. 11. Fractures by Adduction Violence. 12. Fractures of the Medial Malleolus. 13. Fractures by Compression Violence. 14. Unclassified Lesions around the Ankle. 15. Epiphyseal Separations. 16. Surgical Approaches to the Ankle. 17. General Operative Procedure. 18. Late Results and Complications of Ankle Injuries. 19. The Classification of Indirect Injuries to the Ankle. 20. Dislocations and Fracture Dislocations of the Talus. 21. Fractures of the Talus. 22. Difficulties in Classifying Cases. Summaries of Fractures by External rotation, abduction and adduction. Index of References to Authors. General Index.

The contents of this book will appeal mainly to the specialist orthopaedic surgeon. The attempt made to classify injuries to the ankle is as comprehensive as modern knowledge will permit. The minutiae of the various mechanisms by which

ankle injuries are produced are elaborated; where this is not possible, a logical hypothesis is offered.

The author emphasizes that in ankle joint injuries particularly, there are few fractures in which there is not also associated ligamentous damage, generally on the opposite side of the joint. The experienced clinician bases his prognosis on the surrounding soft tissue damage rather than solely on radiological appearances; also 'the secret of satisfactory end results is successful early treatment'. These points are almost fundamental in the treatment of these injuries.

It is surprising to find in a book of this nature (on p. 126) the recommendation that leeches be used to reduce the haematoma!

Several small errors have crept into the book, e.g. the wrong legend under Fig. 239. None of these small mistakes, however, detracts from the main value of the book.

There is an extensive bibliography and a wealth of historical detail about the various types of injury. The author foresees that he might be accused of having made 'too much' of 'too little' and covers himself with the quotation from Bouasse: '*Vous declarez que l'ouvre une porte ouverte. Soit, mais il y a beaucoup de portes ouvertes que l'on croit fermées*'.

This book can be strongly recommended to those who desire more than just a practical knowledge of injuries to the ankle joint.

MOTHERHOOD

Introduction to Motherhood. By Grantly Dick Read, M.A., M.D. (Camb.). (Pp. 92 + xii. With 21 figures. 6s.) London: William Heinemann, Medical Books, Limited. 1950.

Contents: 1. Preface. 2. Introduction. 3. The Female Reproductive Organs. 4. The Ovum. 5. Fertilization of the Ovum. 6. The Commencement of Pregnancy. 7. Hearsay. 8. When to Visit the Doctor. 9. Development of the Uterus and Baby. 10. Nourishment and Protection of the Baby. 11. The Milestones of Pregnancy. 12. The Signs of the Onset of Labour. 13. The Three Stages of Labour. 14. The Placenta or Afterbirth. 15. The Repair of the Perineum. 16. Aspects of Labour from the Woman's Point of View. 17. The Discomforts of Childbirth. 18. The Relief of Pain and Distress in Labour. 19. After the Baby is Born. 20. The Care of the Baby. 21. Preparation of the Breast for Feeding. 22. Preparation of the Nipple. 23. Breast Feeding. 24. On Getting Up. 25. Personal Hygiene. 26. Diet. 27. Heartburn. 28. The Care of the Bowels. 29. The Support of the Pregnant Uterus. 30. Breasts. 31. Posture. 32. Antenatal Exercises. 33. Labour Position. 34. Relaxation. 35. Positions During Labour and Delivery. 36. Games and Recreations During Pregnancy. 37. Postnatal Exercises and Care. 38. The Pelvic Floor. 39. Husband-Wife Relationship During Pregnancy and Childbirth. Index.

General practitioners and specialists are often asked by their patients to recommend books which will provide them with information regarding pregnancy, labour and immediate postpartum care. This small book supplies such information in a simple manner and contains practical advice of a nature suitable for the young mother.

FAVOURITE PRESCRIPTIONS

Favourite Prescriptions. Edited by Sir Heneage Ogilvie, K.B.E., D.M., M.Ch., F.R.C.S., and W. A. R. Thomson, M.D. (Pp. 76. 4s.) London: The Practitioner. 1950.

Contents: 1. Introduction. 2. Favourite Prescriptions. 3. Favourite Prescriptions in General Practice. 4. Favourite Prescriptions in Pulmonary Diseases. 5. Favourite Prescriptions in Diseases of the Nervous System. 6. Favourite Prescriptions in Skin Diseases. 7. Favourite Prescriptions in Diseases of the Ear, Nose and Throat. 8. Favourite Prescriptions in Ophthalmology. 9. Favourite Surgical Prescriptions. 10. Favourite Prescriptions in Physical Medicine. Index.

In recent years prescribing has increasingly become a matter of ordering a specific drug or a proprietary preparation. In practice there are many patients who expect or who must for various reasons be given a 'bottle of medicine', which still plays an important part in the treatment, if not the cure, of the ailment. In this book men with long experience in their specialties give examples of their favourite prescriptions.

On analysis it is difficult to accept some of the prescriptions on the basis of modern pharmacological teaching. It would have been useful to have been given the reasons for the inclusion of certain drugs in some of the 'favourites'. However, young practitioners may learn to use some of the prescriptions with success. Every practitioner has his favourite, and this book can be recommended as a basis for learning the use of 'old-fashioned remedies'.

DIPHTHERIA IN GREAT BRITAIN

A Study of Diphtheria in Two Areas of Great Britain (Medical Research Council Special Report Series No. 272). By P. Hartley, W. J. Tulloch, M. Anderson, W. A. Davidson, J. Grant, W. M. Jamieson, C. Neubauer, R. Norton and G. H. Robertson. (Pp. 162 + viii. 4s.) London: His Majesty's Stationery Office. 1950.

Contents: Part I. The Antitoxin Concentration of the Serum of 62 Inoculated Persons who contracted Diphtheria in Different Areas in England and Wales.
Part II. Clinical Diphtheria in 95 Fully Inoculated and 141 Non-inoculated Persons at Newcastle and Gateshead; with special reference to the Antitoxin Concentration of the Serum of these Persons, of Hospital Nurses, Familial Contacts and Carriers.
Part III. Clinical Diphtheria in 199 Fully Inoculated Children at Dundee; with special reference to the Antigens employed and to the Antitoxin Concentration of the Serum of these Patients and of 211 Inoculated Healthy Children.
Part IV. Comparison of the Results Obtained on Tyneside and at Dundee.

This Special Report of the British Medical Research Council provides fascinating reading, and arises from the facts uncovered by investigations carried out in Dundee (Scotland) and in the Tyneside district of the North-East of England. These investigations were stimulated because, whereas in the rest of the United Kingdom the general experience had been a steady decline in the incidence of diphtheria coincident with the progress of the immunization campaign, in Dundee and in the Tyneside an unusually severe outbreak occurred; furthermore, a considerable proportion of the cases occurred in inoculated persons whom one would expect to have been protected.

The possible repercussions on the success of the immunization campaign can be appreciated. It is comforting to see that the investigations confirm the value of prophylactic injections against diphtheria, because even in the individuals it failed to protect completely the illness was relatively mild, these cases rarely gave rise to anxiety and the risk of complications was much reduced.

It is interesting, too, that the outbreak was associated with the presence of *C. diphtheriae gravis*, a member of the genus which has long been recognized as the greatest potential danger to inoculated persons, possibly due to some other toxic element (perhaps somatic) in its armament, in addition to the common toxin.

A short review such as this cannot begin to describe the painstaking and meticulous work which is behind this report, and those wishing for further knowledge are recommended to read it in full.

PROCTOLOGY

Proctology in General Practice. By J. Peerman Nesselrod, B.S., M.S., M.Sc. (Med.), M.D., F.A.C.S., F.A.P.S. (Pp. 276 + xvii, with 64 figures. £2 11s.) Philadelphia and London: W. B. Saunders Company. 1950.

Contents: 1. Anatomy and Physiology. 2. Diagnostic Procedures. 3. Anal Infection. 4. Hemorrhoidal Disease. 5. Anal Fissure. 6. Anal Abscess and Anal Fistula. 7. Combinations of Anorectal Inflammatory Disease. 8. Preoperative Management. 9. Postoperative Care. 10. Prolapse of the Rectum. 11. Anorectal Malformations. 12. Clinical Proctoscopy. 13. Neoplastic Disease. 14. Anal Pruritus. 15. Miscellaneous Subjects. Index.

Ano-rectal disease plays an important part in general practice. Fissure, pruritus and piles are common complaints and although they tend to be regarded as minor ailments, they are major enough to patients. Too often treatment resolves itself into one or other variant of an analgesic ointment put up by the pharmaceutical houses.

The author of this manual on proctology writes clearly and sensibly on the handling of the commoner rectal complaints. He is particularly good on pre- and post-operative treatment. The operation for piles, for instance, is universally dreaded by patients for fear of pain; yet good post-operative care can do much to make it reasonably painless. There has been a revival of the injection of oil-soluble anaesthetics at operation to diminish post-operative pain. Dr. Nesselrod gives a good account of the possible dangers in the method.

The chapter on pruritus ani unfortunately sheds no more light than do most writings on the subject. It is generally recognized that psychological factors play a prominent part, but where do we go from there?

This book is well printed, well illustrated and full of useful hints. It is confidently recommended to all interested in proctology.

CORRESPONDENCE

A HISTORY OF THE INDIAN MEDICAL SERVICE

To the Editor: It was fitting that when the great medical service, which had done so much for India and for Science, came to an abrupt end in 1947 after nearly 350 years, some general record of its unique work should be written.

This has been done fittingly by Lt.-Col. Donald McDonald, under the title of *Surgeons Twoe and a Barber* from the first reference to the John Company doctors who sailed in the 'foure tall ships' of Captain James Lancaster in December 1600. *Surgeons Twoe and a Barber* tells the fascinating story of this great Service against the background of India from the first beginnings to the end of the British Raj.

The work is fully documented and copiously illustrated. The major part of the edition has been subscribed in advance by former officers of the Indian Medical Service, but a portion has been retained for the interested general public and for those members who for one reason or another did not receive notice of this publication.

Owen R. Evans.

William Heinemann (Medical Books) Ltd.,
99 Great Russell Street,
London, W.C. 1.
24 November 1950.

FREUD OR JUNG

To the Editor: I write to quarrel with the review of Dr. Glover's book, *Freud or Jung*, which appeared in your issue of 2 December.

It is far from clear at times whether your reviewer is expressing his own beliefs or merely paraphrasing those of the author, but to one who has undergone a Jungian training analysis which lasted over two years, such unsupported statements as that 'Jung confesses that he has no theory with which to explain dreams, and he has little to say on the subject of neurosis' are completely inexplicable. The suggestion, too, that Jung, in common with other 'schismatics', has picked the bits of Freud he fancied and ignored the rest, is something less than a half-truth. Jung's concepts of the Universal Unconscious, the Collective Unconscious and the Personal Unconscious surely embrace and outreach the narrower Freudian vision of psycho-sexual growth and development.

The review ends with a fashionable sneer at those minds which lack 'scientific discipline'. Science means knowledge, and I for one fail to see why knowledge acquired through material experiment should be so vastly superior to knowledge gained through exercise of the reason. Philosophy and mysticism have both a right to exist among the human 'sciences', by virtue of seniority if nothing else. The Great Wrangle of our day, between the mystic and the materialist, strikes me as being not unlike a squabble between two people, one of whom has completed the top edge of a jigsaw puzzle, the other the bottom edge, and neither of whom has the middle. I have no personal quarrel with Freud, who by this time, one hopes, has the answer to it all, but I do resent the complacent attitude of his followers, and their sublime disregard of other men who are contributing in no small measure to the ultimate discovery of the real 'missing link'.

R. Dingwall Kennedy.

P.O. Box 370,
Pietermaritzburg.
6 December 1950.

Our reviewer writes: I do not know if Dr. Kennedy wants the questions raised in his letter to be answered; they may be rhetorical. He has misinterpreted the last sentence in the review when he reads into it a veiled and muttered disapproval of mysticism and philosophy. I share Dr. Kennedy's respect for the latter.

I cannot agree that philosophy ought not to be distinguished from the sciences, however, if that is what is implied. Science was originally part of philosophy, but hundreds of years ago scientific problems ceased to be investigated by the purely logical methods of philosophy. Scientific method, the use of observation, measurement, experiment and control, has proved embarrassingly fruitful. It can probably be argued that the success of scientific inquiry is largely due to the limiting of each science to its particular sphere. The business of philosophy, on the other hand is to integrate, not selected portions of experience, but the whole range of experience, and to decide for men what *values* are desirable. Scientists make poor philosophers precisely because their fields of outlook are limited. When the disciplines are confused, unfortunate results usually occur. One is perturbed when Dr. Jung produces a mysterious utterance like the following: 'A perception of the significance of fourness means illumination of the "inner region", a first step, a necessary station on the road of individual development'.

The review was an attempt to reflect a few of Dr. Glover's trenchant criticisms of the Jungian system. They are, of course, amplified in the book, which I again recommend to the correspondent. I do not think Dr. Glover can be accused of 'sublime disregard' of Jung; he must have taken a lot of trouble to write his book, and it is mostly about Jung.

The exercise of reason would be quite a respectable scientific weapon, could one but be sure that all men who exercise their reason are reasonable. Dr. Glover submits that Dr. Jung is not.

X-RAY TREATMENT IN DERMATOLOGY: POET'S CORNER

THE DERMATOLOGIST'S DREAM

To the Editor:

I had a case of keloid once, that followed vaccination,
And the man who put up my machine said it needed radiation.
So I saw the X-ray Commissar who kindly gives permission
For dermatologists like me to do atomic fission.

'I want to give 500 r' I said with bated breath;
'You skin quack' hissed the Commissar, his face as black as death,
'You can't do that in Ballarat, in Sweden it's a crime,
In Liverpool, you silly fool, you'd soon be doing time;
In Birkenhead they shoot you dead; from Iceland to Peru
It's a shocking misdemeanour for dermatologists like you.'

'500 r' the man had said, when he put in the plant—
'Four-fifty' said the Commissar, 'for more than that you can't;
And for the other fifty send the patient round to me,
My technicians will arrange it at a reasonable fee.'

I backed out, humbly beating my forehead on the mat
And asked a passing moujik why the great man was like that.
'He *has* been rather peevish,' said the moujik with a smile,
'Since the day he sat in error on his own Atomic Pile.'

L. J. A. Loewenthal.

Johannesburg.
11 December 1950.

CANING OF SCHOOLBOYS

To the Editor: A recent case has aroused strong personal misgiving. It is, to say the least, disturbing to find that caning of schoolboys by prefects is tolerated in this country. It has, I believe, even been suggested that such procedure is good training! It would be interesting to know, good for whom? No doubt justification is found in the rationalization that what did not obviously kill Grandpa, must be good for grandson!

May I, as a psychiatrist, express my unqualified disapproval of so objectionable a practice. The inculcation of feelings of security and adequacy are difficult enough these days without inflicting on sensitive youngsters the indignity and strain of having to submit to official physical punishment at the hands of immature adolescents. Nor is the deputing of such authority advantageous to the development of the assailant. Corporal chastisement if at all permissible, is essentially the prerogative of a parent. To share this questionable right with a teacher is very debatable; to pass it on to a youngster in his teens is, to my mind, an abuse.

M. Peskin.

139 Lister Building,
Jeppe Street,
Johannesburg.
12 December 1950.

PSYCHO-ANALYSIS

To the Editor: In the *Journal* of 2 December 1950, the reviewer of the book 'Freud or Jung' (1950) by Edward Glover, stated, 'Dr. Glover is an eminent and articulate Freudian' and 'this book . . . should chasten those who, while lacking in knowledge and scientific discipline, yet feel compelled to discredit Freud's remarkable psychological discoveries'.

While holding no brief for the theories of Jung, I yet feel that in view of my letters you kindly published in the issues of 30 September, 10 June and 12 August 1950, it is desirable to add to them this one.

I wish to draw the attention of all medical practitioners to the portion of the Hippocratic Oath reading: 'I will follow that system or regimen, which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to procure abortion. With purity and with holiness I will pass my life, and practice my art.'

Now Dr. Theodore Reik, who wrote,[1] 'In his books and in conversation Freud often named me as one of his friends,' also stated in that same volume: 'After a leeture he (Freud) gave, on the problem of sex, there was raised in the course of the discussion the question of a practical solution for the sexual dilemma of young students. For, on the one hand, psychoanalysis had shown that sexual abstinence was one of the most important factors in the formation of neurosis. On the other hand, the economic circumstances of most students made it impossible for them to marry early. Morality forbade the seduction of young girls, the danger of infection made sexual intercourse with prostitutes inadvisable, and so on.

Freud's advice to the young students was, "Be abstinent, but under protest." He felt that it was imperative to keep alive the inner protest against a social order which prevented mature young men from fulfilling a normal instinctual need. . . . Freud did not believe in sudden and violent revolutions; he put more faith in the steadily mounting, continuous force of patient resistance to bring about ultimately changes in the social order. He believed, also, that psychoanalysis, by making men more straightforward and upright, was one of these reforming forces.'

Freud might just as subtly have suggested to the students who were struggling financially, 'Avoid theft, but under protest'; or to students who had disagreements with or dislikes for their professors, including Freud, 'Avoid murder, but under protest.' The immoral shambles that Freud apparently envisaged as being the ideal at which to aim, would be one where 'the social order no longer forbids the seduction of young girls', and where girls and women willingly seek to be seduced—in their own mental health interests, of course, as well as in the interests of the mental health of their seducers.

That this state of affairs is not merely a nightmarish possibility—particularly for right-thinking parents of daughters—is indicated by an American writer who states: '(In 1946) premarital chastity declined to a point where only one bride in four retained her virginity. Marital chastity as indicated by the divorces, was often only a pious hope.'[2]

Medical practitioners must take sides either for or against this swelling tide of sexual immorality, particularly in view of the sections of the Hippocratic Oath quoted above. It is unethical to take the standpoint, as did Freud, that medicine has nothing to do with morals. To give immoral or even amoral advice to patients or their relatives or friends, is 'deleterious and mischievous' professional behaviour, and in psychological medicine it is equivalent to the contravention of the portion of the Hippocratic Oath reading, 'I will give no deadly medicine to anyone if asked, nor suggest any such counsel.'

Those doctors who may feel awed at the huge leviathan of Freudian following and literature may take courage in piercing that colossal bag of wind, from the words of Dr. Raymond B. Cattell, Professor of Psychology at Duke University, who wrote: 'Freud's Viennese disciples took vows to protect his doctrine against all dangers—even the danger of scientific investigation. They became a Church, excommunicating those who, like Adler, had dared to question the fundamental tenets.

This is no science: it is a farrago of science and fairy-stories, from which, however, the true scientist will not disdain to fish out the good morsels. The attitude of the more open-minded scientists has been that of the rather dejected small boy by the river's bank who, being asked by a gentleman for what he was fishing, replied, "Snigglers". "But what are snigglers?" inquired the gentleman. "How should I know?" replied the boy. "I haven't caught one yet."'[3].

Freud's muddled thinking should become clear to any person with a sound concept of 'right and wrong', 'good and evil', and 'true and false', who reads Freud's writings and the writings of his loyal disciples.

Dr. William McDougall wrote about 'the difference between love and lust, which, though so wide, is so consistently ignored by most psycho-analysts', and this difference was ignored also by the psycho-analysts' high priest and mentor, Sigmund Freud. Indeed, a well-known Freudian psychiatriste told me some time ago that the word 'love' had become meaningless to her, and that the existence of such an emotion was not believed in. So-called 'love', from the Freudian standpoint, is only a manifestation of lust.

It is essential for the mental health of the youth of our country particularly that the question of the 'rightness' or 'wrongness' of Freudian teaching and psychotherapy be settled once and for all, and I have asked the Medical Council to hold an official inquiry into its various aspects.

Any medical practitioners who, like myself, have come in contact with moral wreckage deriving from the acceptance and practice of Freudian teaching on sex matters are requested to get in touch with me, so that the strongest possible case against Freudian psychotherapy may be presented before the South African Medical and Dental Council.

REFERENCES

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2. McPartland, John (1947): *Sex in Our Changing World*. Torchstream Books, London.
3. Cattell, Raymond B. (1931): *Your Mind and Mine*. George Harrap & Co., London.
4. McDougall, William (1944): *An Outline of Abnormal Psychology*. Methuen & Co., London.

J. J. de Villiers, M.B., Ch.B. (Edin.).
224, Brook Street,
Brooklyn,
Pretoria.
12 December 1950.

INFANTILE RICKETS

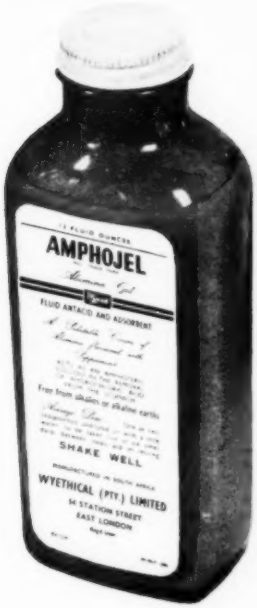
To the Editor: Dr. Feldman's article on *Infantile Rickets* (this *Journal*, 23 December 1950) is most timely. It is to be hoped that his plea for further investigation in South Africa will bear fruit.

My impression is that rickets is far from uncommon among non-European children. In a random two-year period I have had to treat orthopaedically 10 cases of active rickets. These patients, aged 1 to 4 years, excepting one aged 6 years, were brought to *orthopaedic* clinics because of associated deformity. There must have been many more attending paediatric clinics.

However, Dr. Feldman is on uncertain ground when he ascribes *all* bow-leg and knock-knee deformities to rickets. Modern opinion, confirmed by clinical findings, is that *normal* infants undergo a varoid phase (age 1 to 2 years) and a valgoid phase (age 2 to 4 years). Any muscular and consequent ligamentous inefficiency, or overweight, would exaggerate these phases with resultant deformity. This is probably a more frequent cause of deformity in non-European children than rickets, particularly if one remembers that their diets are loaded with carbohydrates without any stiffening. I have seen a few infants up to 4 years old with bow-leg and knock-knee, but with overweight as the only other positive finding.

Native babies are usually carried in shawls on the mothers' backs with their little legs abducted at knees and hips. This may have something to do with their bow-legs; just as it may have some relation to the apparent low incidence of congenital dislocation of the hip among *native* children.

S. Shulman.
Alliance Assurance Bldgs.,
Cape Town.
27 December 1950.



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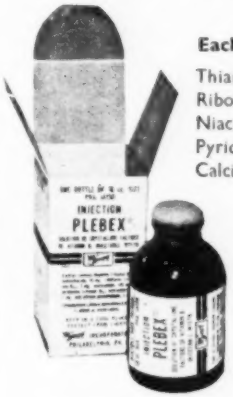

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*Heidelberg	375	40
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*The District Surgeon will also be required to act as medical officer to the School of Industries and the J. W. Luckhoff Opportunity School for which services he will receive additional remuneration on a *per capita* basis. His duties as medical officer at the local pass office will be covered by his annual salary.

The salaries cover all routine services; tariff fees for travelling, operations and certain other services are payable in addition.

The appointments are on part-time basis and private practice is not precluded.

For further information see advertisement in *Government Gazette* or apply to the Secretary for Health, P.O. Box 386, Pretoria, to whom applications, which should reach him before 31 January 1951, should be addressed.

N.B. Testimonials (copies) may be submitted but the Minister of Health wishes it to be known that any candidate will be regarded as disqualified who directly or indirectly canvasses for appointment.

The Medical Association of South Africa
Die Mediese Vereniging van Suid-Afrika

AGENCY DEPARTMENT : AGENTSKAP AFDELING

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Pretoria Hospital – Pretoria University

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Applications are invited from suitably qualified registered specialists for the post of Professor of Medicine and Head of Department of Clinical Medicine, full-time, in the joint service of the Pretoria Hospital and the Pretoria University, on the following conditions:—

Salary: £2,500 per annum (required to produce a satisfactory medical certificate and contribute to the University Teachers' Provident Fund).

Applications should be addressed to the Superintendent, Pretoria Hospital, and should contain full particulars as to age, professional, academic and language qualifications, previous experience and experience in teaching, if any.

The successful applicant will be expected to assume duties on 1 July 1951.

Application forms are obtainable from the Superintendent, Pretoria Hospital.

Applications must reach the undersigned on or before 20 February 1951.

W. Waks
Medical Superintendent

Pretoriase Hospitaal – Pretoria Universiteit

PROFESSOR IN GENEESKUNDE EN HOOF VAN DEPARTEMENT VAN KLINIESE GENEESKUNDE

Aansoeke word ingewag van behoorlike gekwalifiseerde en geregistreerde spesialiteite in interne geneeskunde vir die pos van Professor in Geneeskunde en Hoof van die Departement Kliniese Geneeskunde, voltyds, in die gesamentlike diens van die Pretoriase Hospitaal en die Universiteit van Pretoria, op die volgende voorwaardes:

Salaris: £2,500 per jaar (sal 'n bevredigende mediese sertifikaat moet toon en ook tot die Universiteitsvoorsienings-fonds bydra).

Aansoeke moet aan die Superintendent, Pretoriase Hospitaal, Pretoria, gerig word en moet volledige besonderhede bevat met betrekking tot ouderdom, professionele, akademiese en taal kwalifikasies, vorige ondervinding en onderwyservaring, indien enige.

Van die suksesvolle applikant sal verwag word om dienste op 1 Julie 1951 te aanvaar.

Aansoekvorms is van die Superintendent, Pretoriase Hospitaal, verkrygbaar.

Sluitingsdatum van aansoeke is 20 Februarie 1951.

W. Waks
Mediese Superintendent

Natal Provincial Administration

PORT SHEPSTONE HOSPITAL

Applications are invited from suitably qualified medical practitioners for appointment to a post of visiting medical officer to the Port Shepstone Hospital.

This post carries an honorarium at the rate of £60 per annum and will endure for not longer than 12 months.

Applications should be addressed to the Director of Provincial Medical and Health Services, P.O. Box 20, Pietermaritzburg, to reach him not later than 27 January 1951.

Locum Available

Young doctor willing to do locum during February, March and April in Peninsula area. Own car. £2 10s. per day, excluding car expenses. Write to 'A. E. K.', P.O. Box 643, Cape Town.

Transvaal Provinsiale Administrasie

VAKATURE BY PUBLIEKE HOSPITALE

Aansoeke word ingewag van kandidate met geskikte kwalifikasies vir die onderstaande poste by Publieke Hospitale.

Aansoeke moet gerig word aan die Superintendent van die betrokke hospitaal en moet volle besonderhede bevat aangaande die ouderdom, professionele, akademiese en taalkwalifikasies, ondervinding en huwelikstaat van die applikant en moet voorts 'n aanduiding bevat van die vroegste datum waarop diens aanvaar kan word.

Hospitaal	*Vakature*	*Emolumente*	*Opmerkings*
Heidelberg	Verantwoordelike Geneesheer (1)	£1,000–40–1,200	Getroud plus (*a*) hieronder. Ongetroud plus (*b*) hieronder. Plus £180 p.j. huistoelae.
Johannesburg Hospitaalbestuur en Universiteit van Witwatersrand			
	Tydelike Geneesheer (1) (Asst. Dosent)	£1,200	Tydelike aanstelling vir ses maande vanaf *12 Februarie 1951*. Getroud plus (*a*) hieronder. Ongetroud plus (*b*) hieronder.
Klerksdorp	Deeltydse Algemene Praktisyn/Chirurg (1)	£340 p.j.	Twee sessies per week teen £170 per sessie.
Ontdekker's Gedenk, P.K. Florida	Verantwoordelike Geneesheer (1)	£1,200–50–1,500	Getroud plus (*a*) hieronder. Ongetroud plus (*b*) hieronder. Plus £180 p.j. huistoelae.
Sabie	Huisdokter (1)	£240 p.j.	Plus vry losies, inwoning en wasgoed. Getroud plus (*c*) hieronder. Ongetroud plus (*d*) hieronder.

(*a*) £208 per jaar lewenskostetoelae.
(*b*) £50 per jaar lewenskostetoelae.
(*c*) £91 per jaar lewenskostetoelae.
(*d*) £25 per jaar lewenskostetoelae.

Van die persone wat aangestel word, sal verwag word om bevredigende sertifikate in te dien, asook om hulle te onderwerp aan 'n geneeskundige ondersoek by die betrokke hospitaal.

Aansoekvorms is verkrygbaar van die Provinsiale Sekretaris, Departement van Hospitaaldienste, Posbus 383, Pretoria.

Benewens jaarlikse salaris ontvang voltydse werknemers op die oomblik lewenskostetoelae en word verlof toegestaan ooreenkomstig die hospitale verlofregulasies.

Die sluitingsdatum van aansoeke vir poste is 24 Januarie 1951.

Provincial Administration of the Cape of Good Hope

(HOSPITAL DEPARTMENT)

HOSPITAL BOARD SERVICE: FRERE HOSPITAL, EAST LONDON: VACANCY FOR ORTHOPAEDIC SURGEON (PART-TIME)

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2. Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Provincial Building, Wale Street, Cape Town, or from the Branch Representative of the Hospitals Department at Cape Town (P.O. Box 1487); Port Elizabeth (P.O. Box 80); East London (P.O. Box 13); Kimberley (P.O. Box 618) and Umtata (P.O. Box 202), or from the Medical Superintendent of any provincial hospital or the Secretary of any school board in the Cape Province.

3. The completed application forms must be addressed to the Director of Hospital Services, P.O. Box 2060, Cape Town, and must reach him not later than 20 January 1951. Candidates must state the earliest date on which they can assume duty.

Vanderbijl Park Health Committee

VACANCY: PART-TIME CLINICAL MEDICAL OFFICER

Applications are invited from bilingual qualified persons for the position of part-time clinical medical officer in the Committee's service at a salary of £41 13s. 4d. per month, including cost-of-living allowance.

The successful applicant will be required to carry out part-time clinical duties in the Committee's non-European Clinic, District N.W. 2.

Further particulars in connection with the position may be obtained from the undersigned.

Applications giving details of qualifications, experience, age and the earliest date on which duties can be assumed, will be received by the undersigned up to noon on Friday, 26 January 1951.

P. R. Nell
Acting Secretary

P.O. Box 3
Vanderbijl Park
21 December 1950
Notice No. 26/1950

Printed by Cape Times Ltd., Parow, and Published by the Proprietors, THE MEDICAL ASSOCIATION OF SOUTH AFRICA, MEDICAL HOUSE, 35 Wale Street, Cape Town. P.O. Box 643. Telephone 2-6177. Telegrams: 'Medical'